

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04321

Reg. Dist. No.

4349

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparrows Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rheem Co North Point Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Raymond</u> (Middle) <u>T</u> (Last) <u>Adamson</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>23</u> (Year) <u>55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 15 1920</u>
9. AGE last birthday <u>35</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>production sec</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rheem Mfg</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alex Adamson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>VCS</u> <u>2</u>		16. SOCIAL SECURITY No. <u>Virginia Adamson 106 Kinship Rd</u>	
17. INFORMANT AND ADDRESS <u>Virginia Adamson 106 Kinship Rd</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Coronary Occlusion</u>			
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>MD Dawn M. H. - Dundalk - Md</u>		DATE SIGNED <u>5/24/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>		LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-25-55</u>		REGISTRAR'S SIGNATURE <u>Hedrick</u>	
24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>		ADDRESS <u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4350

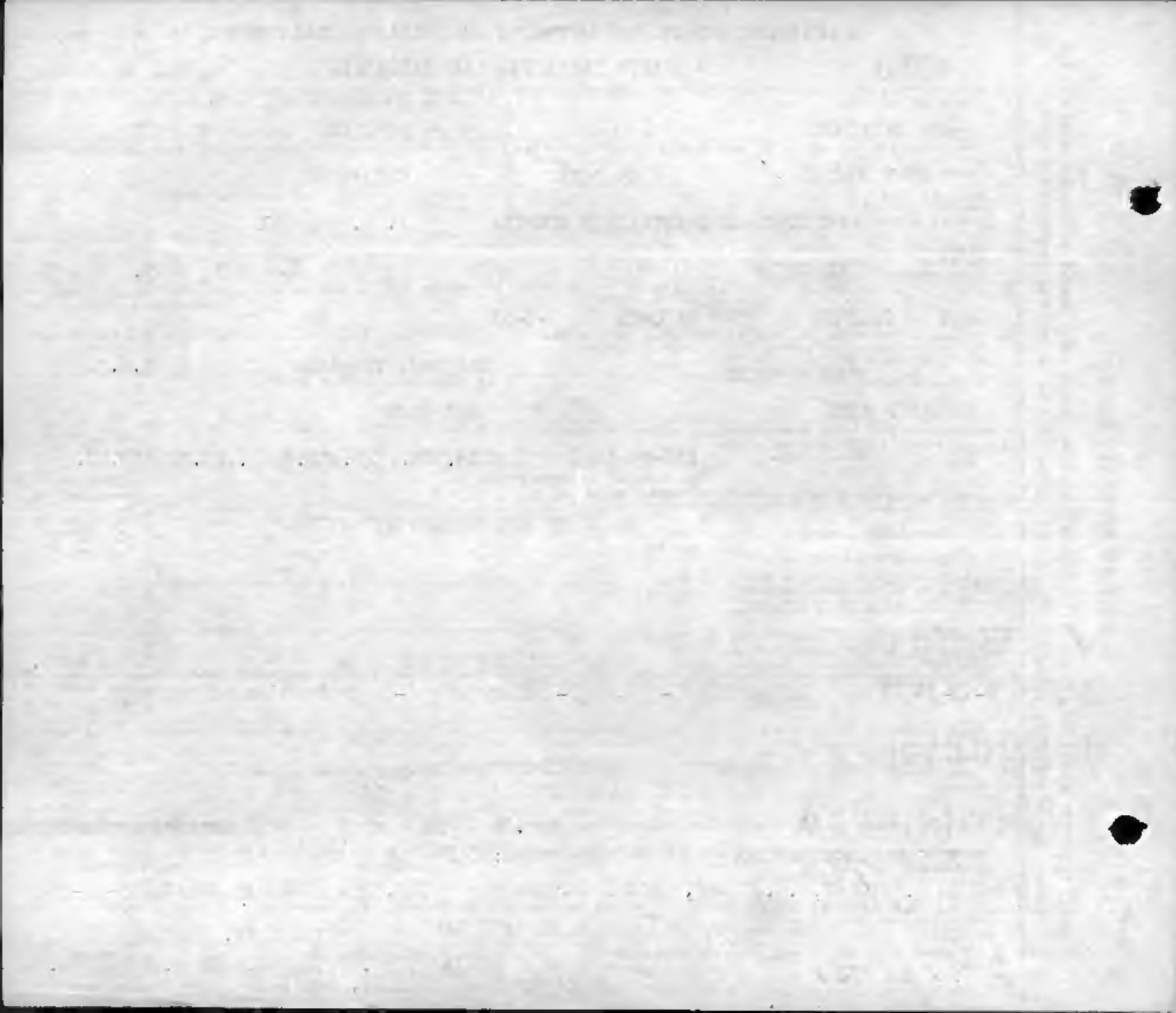
CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY SOMERSET
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN FORT HOWARD	45 DAYS	TOWN CRISFIELD	19-39-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
50 VETERANS ADMINISTRATION HOSPITAL		P. O. BOX 481	✓
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
BENJAMIN (NMI) AMES		MAY 9, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
MALE	COLORADO	WIDOWED	3-5-93
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
62 yrs.		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
OYSTER SHUCKER			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Accomac, Virginia		U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
BENJAMIN AMES		MARY BYRD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service:		16. SOCIAL SECURITY NO.	
1 YES WW-1		217-03-7865	
17. INFORMANT & ADDRESS:			
CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 705.1 ERYTHEMA MULTIFORME EXUDATIVUM		2 WEEKS	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		UNKNOWN	
OSTEOCHONDROMA OF VERTEBRA			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
4-11-55		Laminectomy L-4&5, Hemi-Laminectomy L-3 & exploration of cauda equina	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar. 25, 1955, to May 9, 1955, that he has been deceased since Mar. 25, 1955 and that death occurred at 6:55 PM, from the causes and on the date stated above.			
SIGNATURE Francis G. Dickey		DATE SIGNED 5-10-55	
FRANCIS G. DICKEY, M.D., Chief, Medical Service, VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
BURIAL		BALTIMORE NATIONAL	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)	
5/12/55		BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS	
ARLINGTON S. PHILLIPS		1808 N. MORRIS ST. BALTIMORE 17, MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4351

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04323 ^{WC}

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Spawna Pk.</u> LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spawna Pk. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>2510 Madison Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>L. Roy</u> (Middle) <u>WILLIAM</u> (Last) <u>Anderson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>5-25</u> 19 <u>55</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH (Month) (Day) (Year) <u>Nov. 25, 1901</u>
9. AGE last birthday <u>54</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Conetta, Kansas</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabman</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stacy Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0213-07-6821</u>	
17. INFORMANT'S NAME AND ADDRESS <u>Mr. Roy Anderson</u> <u>2510 Madison Ave.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
 Immediate cause

(a) Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

10 min.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office hldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR



4352

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	31014
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Codd Nursing Home</u>		STREET ADDRESS (If rural give location) <u>1224 N. Calvert St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Rhea</u>	(Middle) <u>Magness</u>	(Last) <u>Armstrong</u>	(Month) <u>May</u> (Day) <u>14</u> (Year) <u>1955</u>
(Type or Print)			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>1878</u>
			9. AGE last birthday: <u>77</u> yrs.
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>Henry Magness</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
(If Yes, give war or dates of service) <u>None</u>		17. INFORMANT & ADDRESS: <u>Family Records</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) <u>Cerebral Haemorrhage</u>			
Antecedent causes (s) (b) <u>Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
12a. DATE OF OPERATION: <u>May 17, 1955</u>		12b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 1954, to <u>May</u> , 1955, that I last saw the deceased alive on <u>5/11/55</u> , 1955, and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>M. E. Quinn</u>		ADDRESS <u>TIMONIUM</u>	
(Degree or title) <u>M.D.</u>		DATE SIGNED <u>5/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>May 17, 1955</u>	<u>New Cathedral Cemetery</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 16, 1955</u>	<u>Mabel C. Gray</u>	<u>John Burnie' Sons</u>	<u>Towson, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1905

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto. City</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> OR TOWN <u>3701 1/2</u> STREET ADDRESS <u>formerly of - give location</u> <u>3300 N. Calvert Street</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Anne L. Ansel</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>5</u> <u>17</u> <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>Nov. 30, 1871</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>John N. Grant</u>		14. MOTHER'S MAIDEN NAME: <u>Emily Buckham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE (A) <u>Pulmonary Infarct Embolus</u> ANTECEDENT CAUSE (B) <u>Hypertensive Cardiovascular disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized severe arteriosclerosis</u>		<u>unknown</u> " "	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 19, 1937, to May 17, 1955, that I last saw the deceased alive on <u>5.17</u> , 19 <u>55</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Gertrude J. Fleischer</u> ADDRESS <u>M.D. Spring Grove</u> DATE SIGNED <u>5.17.55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-19-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
FUNERAL DIRECTOR <u>Wm. J. Pickens & Sons</u>		ADDRESS <u>Baltimore 17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04326

4354

CERTIFICATE OF DEATH

Reg. Dist. No. *58*

1. PLACE OF DEATH COUNTY BALTIMORE COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS TOWSON NURSING HOME		STREET ADDRESS (If rural, give location) 3117 BELAIR ROAD	
3. NAME OF DECEASED (Type or Print) ELIZABETH BAER		4. DATE OF DEATH MAY 10, 1955	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW		8. DATE OF BIRTH JAN. 14, 1872	
9. AGE last birthday 83 yrs.		10. If under 1 year: Months 1 Days 1 Hours 1 Min.	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE GRAU SR.		14. MOTHER'S MAIDEN NAME ELIZABETH ROTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT AND ADDRESS MRS KATHERINE HALL		18. SAME.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Chronic myocarditis

Antecedent cause(s)

(b)

Heart & coronary

Disease or condition, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from *5-10*, 19*44*, to *5-10*, 19*55*, that I last saw the deceased alive on *5-6*, 19*55*, and that death occurred at *10* P. M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

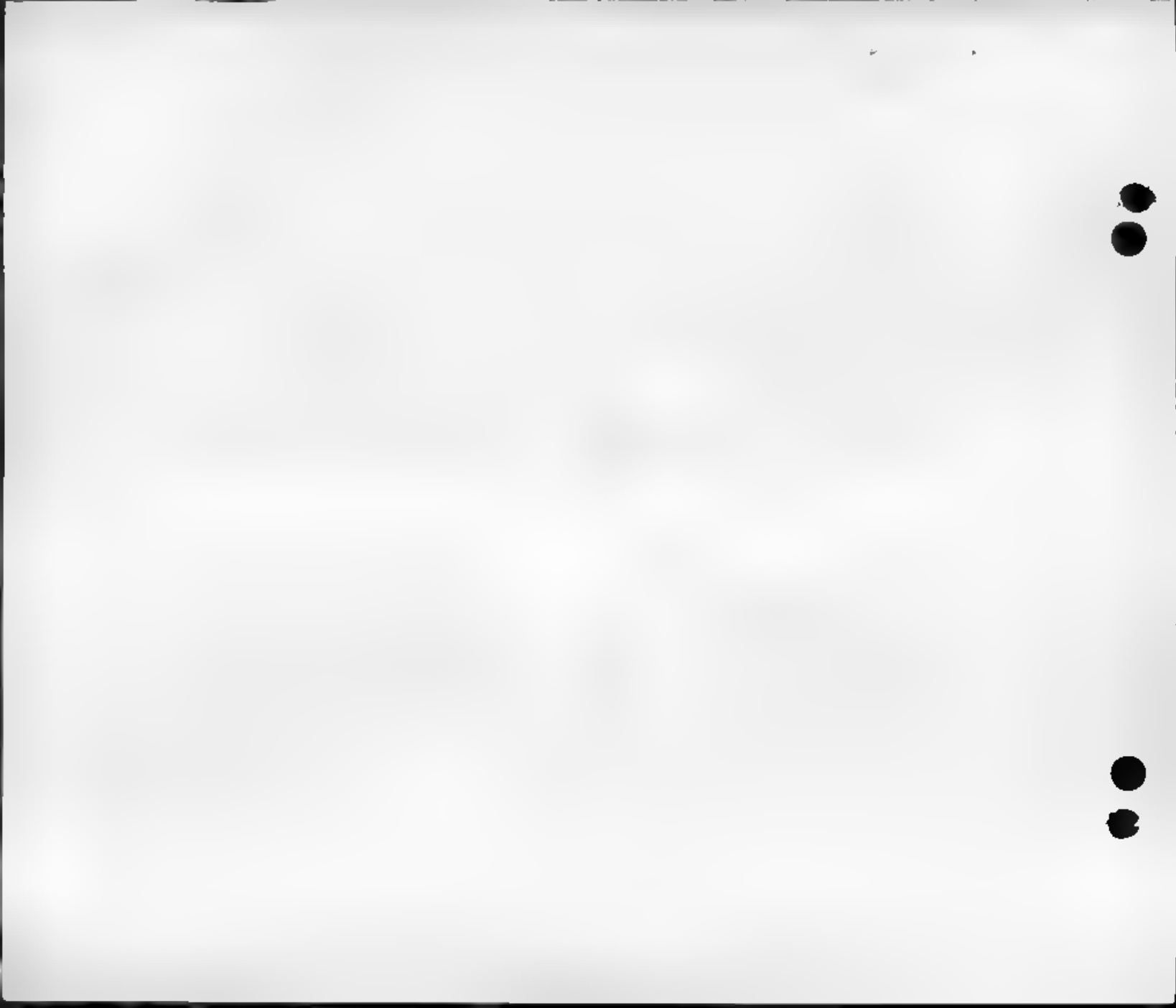
HENRY SANDER & SONS INC.

BALTIMORE MARYLAND.

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4355

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04327

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ruxton</u> LENGTH OF STAY (in this place) <u>9 months</u>				TOWN <u>Ruxton</u>			
HOSPITAL OR NSTITUTION OR STREET ADDRESS <u>1300 Berwynck Avenue</u>				STREET ADDRESS (If rural, give location) <u>1300 Berwynck Avenue</u>			
3 NAME OF DECEASED (First) (Middle) (Last)				4 DATE OF DEATH (Month) (Day) (Year)			
<u>Marion Valentine Bailliere</u>				<u>May - 12 1955</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)		8 DATE OF BIRTH <u>Apr. 19-1884</u>	
9 AGE last birthday <u>71</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>		11 BIRTHPLACE State or foreign country <u>Ohio</u>		12 CITIZEN OF WHAT COUNTRY?	
10A U.S. AL OCC. PAT. ON Give kind of work done during most of working life. even if retired <u>Retired Consulting Engineer</u>				10B KIND OF BUSINESS OR INDUSTRY			
13 FATHER'S NAME <u>Frederick H. Bailliere</u>				14 MOTHER'S MAIDEN NAME <u>Evalina Mary Tabb</u>			
15 WAS DECLARED DEAD IN U.S. ARMED FORCES? (Yes, no, or unk) <input checked="" type="checkbox"/> If Yes, give war or dates of service <u>?</u>				16 SOCIAL SECURITY NO. <u>270-09-9666A</u>			
17 INFORMANT & ADDRESS <u>Mrs. Evang W. Brand (daughter) Ruxton</u>				18 MEDICAL CERTIFICATION			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
5781 IMMEDIATE CAUSE (A) <u>Hemorrhage, Gastro-intestinal Massive -</u>							
ANTECEDENT CAUSE (B) <u>Cause unknown</u>							
DISEASES OR CONDITIONS FANY G.V NG RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C) <u>Arteriosclerotic Cardio-vascular disease 7 years</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION			
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc)			
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21D. TIME (Month) (Day) (Year) (Hour) (Minute)				21E. INJURY OCCURRED (While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Aug 14, 1954</u> , to <u>May 12, 1955</u> , that I last saw the deceased alive on <u>May 12, 1955</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above							
SIGNATURE <u>Dr. J. S. Watson</u>				DATE SIGNED <u>May 13, 1955</u>			
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>May 16, 55</u>			
NAME OF CEMETERY OR CREMATORY <u>Waverly Church</u>				LOCATION (City, town or county) (State) <u>Conestoga Co., Virginia</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5-13-55</u>				24 FUNERAL DIRECTOR <u>Stewart & Mowen Co., 108 W. North Ave</u>			



4356

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> LENGTH OF STAY (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armaccost Nursing Home</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>1807 East 31st Street #18</u>	
3. NAME OF DECEASED (First) <u>MARY</u> (Middle) <u>Agnes</u> (Last) <u>Bannon</u> (Type or Print) <u>MARY Agnes Bannon</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>May 25th 1955</u>	
5 SEX <u>female</u> 6 COLOR OR RACE <u>white</u> 7 SINGLE MARRIED WIDOWED DIVORCED (Specify): <u>single</u>		8 DATE OF BIRTH <u>JAN 20 1891</u> 9 AGE last birthday <u>63</u> yrs. Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Shirt Mfg.</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Michael Bannon</u>		14 MOTHER'S MAIDEN NAME <u>Margaret ?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT & ADDRESS <u>Mr. Vincent Lowe, 313 Worthington Rd #4</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>181X</u> IMMEDIATE CAUSE (A) <u>General Carcinomatosis</u> ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) <u>Carcinoma of Bladder</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a DATE OF OPERATION <u>1/7/55</u>		19b MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b PLACE (Home, farm, factory street, office bldg., etc.)	
21c WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21e INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/15</u> , 19 <u>53</u> , to <u>5/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>55</u> , and that death occurred at <u>6:30</u> A.M., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS <u>M D 2320 Eutam Rd</u> DATE SIGNED <u>5-25-55</u>			
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-27-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, 5305 Harford Road #14</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Israel Zinberg
2320 Eutaw Place
LA 3 5737

2-1-6

04329

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

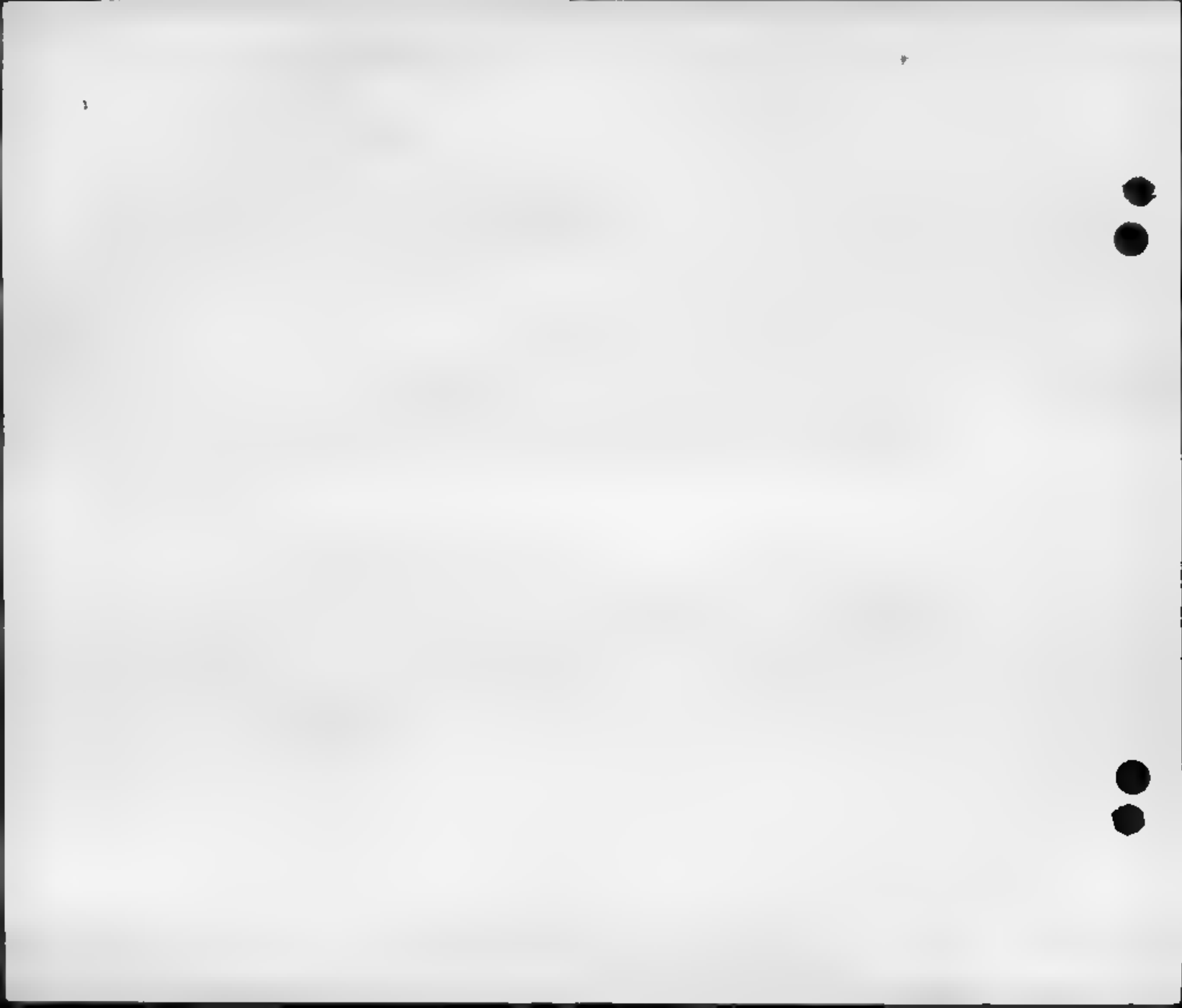
Reg. Dist. No.

4357

1. PLACE OF DEATH - COUNTY		BALTIMORE 19 MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE		MD		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		SPARROW Pt. 4890		CITY (If outside corporate limits, write RURAL and give nearest town)		MD					
HOSPITAL OR INSTITUTION OR STREET ADDRESS		7700 Bay Front Rd.		STREET ADDRESS		#1.		(If rural, give location)			
3. NAME OF DECEASED (Type or Print)		CHARLES		(Middle)		BARTOSH		(Last)		4. DATE OF DEATH	
5. SEX		Male		6. COLOR OR RACE		White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		MARRIED	
8. DATE OF BIRTH		Dec 5, 1889		9. AGE last birthday		65 yrs.		10. MONTHS		5	
11. BIRTHPLACE (State or foreign country)		Lithuania		12. COUNTRY OF WHAT COUNTRY?		Same		13. FATHER'S NAME		Kagmer Bartosh	
14. MOTHER'S MAIDEN NAME		Antonia Ushniouka		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		No		16. SOCIAL SECURITY No.		216-32-9610	
17. INFORMANT AND ADDRESS		Agatha Bartosh (wife)		18. MEDICAL CERTIFICATION		as above		19. DATE OF OPERATION		1955	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE		(Specify)		22. I hereby certify that I attended the deceased from		Sep 5, 1951 to May 5, 1955	
23. BUHAL CREMATION REMOVAL (Specify)		Cremated		24. DATE THEREOF		May 9		25. NAME OF CEMETERY OR CREMATORY		London Park	
26. DATE REC'D BY LOCAL REG.		May 9		27. REGISTRAR'S SIGNATURE		Charles W. Bartosh		28. FUNERAL DIRECTOR		Charles W. Bartosh	
29. ADDRESS		6908 N. P. Rd. Balto. 19. Md		30. DATE SIGNED		5/5/55		31. SIGNATURE		Louis N. Tallin M.D.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

4358

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04350 33

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> county <u>Howard</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Owings Mills</u>		LENGTH OF STAY (in this place) —		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Jessups</u>		<u>12 X 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Training School</u>				STREET ADDRESS (If rural, give location) —			
3. NAME OF DECEASED: (First) <u>Alma</u> (Middle) <u>Eugenia</u> (Last) <u>Basford</u>		4. DATE OF DEATH: (Month) <u>5</u> (Day) <u>23</u> (Year) <u>1955</u>					
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>10/23/06</u>	
9. AGE last birthday <u>48</u> yrs		10. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph S. Basford</u>				14. MOTHER'S MAIDEN NAME: <u>Isabel Reely Basford (Deceased)</u>			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>Rosewood Records</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
49. X Immediate cause		(a) <u>Broncho - Pneumonia, Acute -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 mos</u>			
Antecedent cause(s)		(b) <u>Bronchitis, Acute -</u>		<u>2 weeks</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u>—</u>					
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>—</u>				19b. MAJOR FINDINGS OF OPERATION: <u>—</u>			
20. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory street OF office bldg., etc.)		(CITY OR TOWN)		COUNTY (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>5/4/55</u> to <u>5/23</u> , 1955, that I last saw the deceased alive on <u>5/23</u> , 1955, and that death occurred at <u>9:30</u> a.m., from the causes and on the date stated above.							
SIGNATURE <u>Harry G. Butler M.D.</u>		ADDRESS <u>Owings Mills, Maryland</u>		DATE SIGNED <u>May 25-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lavaca Cemetery</u>		LOCATION (City, town or county) (State) <u>Lavaca, Md.</u>	
DATE REC'D BY LOCAL REGISTRY <u>May 25-1955</u>		REGISTRAR'S SIGNATURE <u>Mary Elmer</u>		24. HEALTH DIRECTOR'S SIGNATURE <u>Robert Smalley Laurel, Md.</u>		ADDRESS <u>—</u>	

U. S. A. 101

101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film 181 5-16-55 et

04331

4359

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u> LENGTH OF STAY (in this place) <u>60 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Catonsville Nursing Home</u>		STREET ADDRESS (If rural give location) <u>Frederick Rd. & N. Nursery Lane</u>	
3 NAME OF DECEASED (First) <u>CONRAD</u> (Middle) <u>BECKER</u> (Last) <u>BECKER</u>		4 DATE (Month) <u>May</u> (Day) <u>9th.</u> (Year) <u>1955</u>	
5 SEX <u>Male</u> 6 COLOR OR RACE <u>White</u> 7 SINGLE MARRIED WIDOWED DIVORCED <u>Widower</u> 8 DATE OF BIRTH <u>7/19/1856</u>		9 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. <u>98</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Merchant</u>		10B KIND OF BUSINESS OR INDUSTRY <u>Grocery Business</u>	
11 BIRTHPLACE (State or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Unknown</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT & ADDRESS <u>Mr. W. F. Becker 6224 Frederick Ave. Catonsville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE <u>422.1</u>		(A) <u>Myocardial failure</u>	
ANTECEDENT CAUSE (E)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B) <u>A.S.C.V.D.</u>	
		(C) <u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
19A DATE OF OPERATION <u>6</u>		19B MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc. INJURY OCCUR? (City or town) (County) (State)	
21C TIME (Month) (Day) (Year) OF INJURY		21D INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21E HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 27, 1950</u> , to <u>5-9</u> , 1955, that I last saw the deceased alive on <u>5-4</u> , 1955, and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Stephen Lee Magnus</u> M.D. <u>Catonsville</u>		DATE SIGNED <u>5-10-55</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>Easton Sons</u>		ADDRESS <u>Catonsville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11-11-11

4360

CERTIFICATE OF DEATH

Reg. Dist. No. 37

Items 8, 9, 12 Film 181 5-19-55 et

I. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Texas - Cockeysville P.O. (In this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Baltimore County Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Balto.
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Sparrows Point
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

JOHN

BIELECKI

5. SEX:

COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

4. DATE OF DEATH:

(Month)

(Day)

(Year)

MALE WHITE

WIDOWED

Unknown

Approx. 70 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

FARM LABORER

FARM

White Russia here since 1917

Unknown

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS:

3 no

no

220-01-1735

Mrs. Julia Orndorff - 2407 Ruth Ave. Sparrows Point

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardiac decompensation

DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Atherosclerosis cordis - vascular disease

DUE TO

(c)

Interval Between Onset And Death

years

years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 13, 1953, to May 14, 1955, that I last saw the deceased

alive on May 14, 1955, and that death occurred at 6 30 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Elizabeth B. Skurull M.D.

Cockeysville, Md. 5/14/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

MAY 14/55

FUNERAL DIRECTOR

ADDRESS

MAY 14/55

Wm. J. Schuchman

L. Earl Sparks Sparks, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly

S. A. C. M. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4342

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04333

Item 8, Film G183, 6/30/55

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>2</u> <u>Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> <u>OR TOWN</u>		STATE <u>Md</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> <u>OR TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED: (Type or Print, First Middle Last)				4. DATE OF DEATH: (Month Day Year)			
<u>Flora Mae Buep</u>				<u>May 18 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 14 1887</u>	9. AGE last birthday: <u>67</u> yrs	10. UNDER 1 YEAR 11. UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>				13. FATHER'S NAME: <u>John Buep</u>			
14. MOTHER'S MAIDEN NAME: <u>Flora Mae Buep</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>Yes</u> (Yes, give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY No. <u>None</u>				17. INFORMANT & ADDRESS: <u>Dr. Raymond H. Buep, 471 E. 1st St., Baltimore, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
163X Immediate cause (a) <u>Myocardial infarction</u> DUE TO <u>Coronary atherosclerosis</u>							
Antecedent cause(s) (b) <u>Chronic hypertension</u> DUE TO <u>Chronic hypertension</u>							
I causes or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE		Specify: PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY, (STATE))	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED		HOW DID INJURY OCCUR?			
		White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>21.0. 1954</u> , to <u>5.18. 1955</u> , that I last saw the deceased alive on <u>5.18. 1955</u> , and that death occurred at <u>11.00 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE		DEGREE OR TITLE		ADDRESS		DATE SIGNED	
<u>John E. W. Buep</u>		<u>MD</u>		<u>471 E. 1st St., Baltimore, Md.</u>		<u>5/18/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>5-21-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Baltimore</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>5-19-55</u>		REGISTRAR'S SIGNATURE: <u>A. W. Buep</u>		24. FUNERAL DIRECTOR: <u>Baltimore</u>		ADDRESS: <u>Baltimore</u>	

4361

CERTIFICATE OF DEATH

Reg Dist No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard	LENGTH OF STAY (in this place) 8 Days	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
TOWN Fort Howard		TOWN Baltimore	
HOSPITAL OR INSTITUTE OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural give location) 600 W. North Avenue	
3 NAME OF DECEASED (First) (Middle) (Last) EARL S. BISHOP		4 DATE (Month) (Day) (Year) OF DEATH May 6, 1955	
5 SEX Male	6 COLOR OR RACE White	7 SINGLE MARRIED Married	8 DATE OF BIRTH 1/14/89
9 AGE last birthday 66 yrs		10 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Carpenter		10B KIND OF BUSINESS OR INDUSTRY Consolidated Engrs.	
11 FATHER'S NAME Stephen S. Bishop		12 CITIZENSHIP OF WHAT COUNTRY? U. S. A.	
13 MOTHER'S MAIDEN NAME Mary Robbins		14 MOTHER'S MAIDEN NAME Mary Robbins	
15 INFORMANT'S ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		16 INFORMANT'S ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	
17 MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
18 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	
(A) IMMEDIATE CAUSE PRIMARY LEFT THORACIC-INLET TUMOR WITH WIDESPREAD METASTASES TO BONE.		(B) ANTECEDENT CAUSE (S) UNKNOWN	
(C) DUE TO		(D) DUE TO	
20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
21A DATE OF OPERATION		21B MAJOR FINDINGS OF OPERATION	
21C ACCIDENT WAS UNDERLYING CAUSE OF DEATH		21D PLACE (Home, farm, factory, street, office, etc.) OF INJURY	
21E TIME (Month) (Day) (Year) (Hour) OF INJURY		21F INJURY OCCURRED While at work Not while at work	
21G WHERE DIED (City or town) (County) (State)		21H HOW DID INJURY OCCUR?	
22 I hereby certify that I attended the deceased from Apr. 28, 1955 to May 6, 1955 and that death occurred at 11:15 P.M. from the causes and on the date stated above			
SIGNATURE William B. Vandegriest		DATE SIGNED 5/7/55	
23 BURIAL CREMATION DATE THEREOF Burial MAY 10, 1955		NAME OF CEMETERY OR CREMATORY Baltimore National	
LOCATION Baltimore, Maryland		24 FUNERAL DIRECTOR William Cook-Blight Inc.	
DATE REC'D BY LOCAL REGISTRAR		ADDRESS 6009 Harford Rd Balto., Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15—10-53

MARGIN RESERVED FOR BINDING

(E)

X

X

LEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04335

4362

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1 PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> OR TOWN <u>PIKESVILLE</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> OR TOWN <u>PIKESVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4111 COLONIAL Rd</u>		STREET ADDRESS (If rural give location) <u>4111 COLONIAL Rd</u>	
3 NAME OF DECEASED (First) (Middle) (Last) <u>FRANKLIN WALTER Bitz Sr.</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>MAY 16 1955</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8 DATE OF BIRTH <u>MARCH 17, 1892</u>
9 AGE last birthday <u>62</u> Months <u>7</u> Days <u>22</u> Hours <u>0</u> Min.		10 USUAL OCCUPATION (Give kind of work done during most of working life) <u>Partner Manager</u>	
11 KIND OF BUSINESS OR INDUSTRY <u>Partners Brothers</u>		12 BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>	
13 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14 MOTHER'S MAIDEN NAME <u>Emma G. Mueller</u>	
15 FATHER'S NAME <u>William J. Bitz</u>		16 MOTHER'S NAME <u>Emma G. Mueller</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		18 SOCIAL SECURITY NO. <u>215-02-5193</u>	
19 MEDICAL CERTIFICATION 19A DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>157X</u> IMMEDIATE CAUSE (A) DUE TO <u>Cerebral thrombosis</u> ANTECEDENT CAUSE (B) DUE TO <u>Biliary Obstruction</u> DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Carcinoma of the head of the Pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 wks</u> <u>1 year</u>	
20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Jaunder</u>			
21A DATE OF OPERATION <u>April 1955</u>		21B MAJOR FINDINGS OF OPERATION <u>Cn of the Pancreas</u>	
21C ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner) <input type="checkbox"/>		21D PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	
21E TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21F INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>1945</u> , to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.		23 BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> DATE THEREOF <u>MAY 20, 1955</u> NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u> LOCATION (City, town, or county) <u>WOODLAWN MD</u>	
24 DATE REC'D BY LOCAL REGISTRAR <u>MAY 18, 1955</u> REGISTRAR'S SIGNATURE <u>Frank H. Newell</u>		25 FUNERAL DIRECTOR ADDRESS <u>Frank H. Newell Pikesville MD</u>	

RECEIVED

1977

RECEIVED

4363

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1 PLACE OF DEATH.

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) _____
 TOWN Immediately North of 10 years
 HOSPITAL OR INSTITUTE OR _____
 STREET ADDRESS Baltimore City Line
5908 Liberty Road

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town) _____
 OR TOWN Immediately North of City Line
 STREET ADDRESS _____
5908 Liberty Road

3 NAME OF DECEASED.

First

Middle

(Last

4. DATE

(Month,

Day

(Year)

Type or Print.

MaryM.Boone

OF

DATE

May201955

5. SEX:

6 COLOR OR

7. SINGLE, MARRIED,

8. DATE OF BIRTH:

9. AGE last birthday

10. MONTH 1 YEAR

11. IN MONTH 24 HRS.

12. MONTH

13. DAYS

14. HOURS

15. MIN

Female

White

WIDOWED, DIVORCED,
(Specify): MarriedSept. 28, 18886677201955

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Joseph Kelly

14 MOTHER'S MAIDEN NAME

Susan Isennoek

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk)

16 Social Security No.

17. INFORMANT & ADDRESS:

NoWilliam W. Boone 5908 Liberty Road

18. MEDICAL CERTIFICATION

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 X
Immediate cause

(a)

DUE TO

CARCINOMA OF UTERUS

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

2 YRS

11 OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

2-10-55BIOPSY - UNDIFFERENTIATED CARCINOMA

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office, bldg, etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at

Not While

Work ☐At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-5, 1955, to 5-20, 1955, that I last saw the deceased alive on 5-18, 1955, and that death occurred at 3:45 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

B. Stanley CohenMD7306 Liberty RdBaltimore 7 5-20-55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION City town or county

(State)

Burial

May 21, 1955New CathedralBaltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

23 57 24HedrickBurgee Funeral Home3631 Falls RoadNorace F. Burgee

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04337

4364

CERTIFICATE OF DEATH

Reg. Dist. No. ... 45

1. PLACE OF DEATH- COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) BOWLEYS QUARTERS		CITY (If outside corporate limits, write RURAL and give nearest town) BOWLEYS QUARTERS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS BOX 2950 ROUTE 15		STREET ADDRESS (If rural, give location) BOX 2950 ROUTE 15	
3. NAME OF DECEASED (First) (Middle) (Last) ARTHUR WATSON BORDLEY		4. DATE OF DEATH (Month) (Day) (Year) MAY 27, 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH JAN. 25, 1887
9. AGE last birthday 67 yrs.		10. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPPL. TERMINAL WAREHOUSE		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME HARRY F.F. BORDLEY		14. MOTHER'S MAIDEN NAME MARY THOMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. 212 10 5581	
17. INFORMANT AND ADDRESS MRS ALWYN HUNDLEY JR.		18. ADDRESS 3143 ABELL AVE.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		14. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
2. IMMEDIATE CAUSE 3-1X		(a) Cerebro-vascular accident		8 hrs.	
3. ANTECEDENT CAUSE(S) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Cerebral arteriosclerosis		?	
4. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		(c) Rheumatoid arthritis, severe		10 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 9, 1955 , to Nov. 25, 1954 , that I last saw the deceased alive on Nov. 25, 1954 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.					
SIGNATURE Maxwell Goldstein		ADDRESS M.D. 5334 Liberty Heights Ave.		DATE SIGNED 5/28/55	
23. BURIAL CREMATION REMOVAL (Specify)		DATE MAY 31, 1955		NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	
DATE REC'D BY LOCAL REG. 5-31-55		REGISTRAR'S SIGNATURE A W Hedrick		LOCATION (City, town, or county) (State) WOODLAWN MARYLAND.	
				24. FUNERAL DIRECTOR HENRY SANDER & SONS INC.	
				ADDRESS BALTIMORE MARYLAND	

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

4365 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04338

tem 12, File G192 5-31-53

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY <u>Catonsville</u> (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> (If rural give location) HOSPITAL OR INSTITUTE OR ADDRESS <u>Spring Grove St Hosp.</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u> CITY <u>Glen Arm</u> (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Arm</u> (If rural give location) STREET ADDRESS <u>Box 294-C Harford Rd.</u>	
3 NAME OF DECEASED (Type or Print) <u>BRUNO Bernard</u> (Last) 4 DATE OF DEATH <u>5 17 1955</u> 5 SEX <u>M</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <u>WIDOWED</u> 8 DATE OF BIRTH <u>10 16 1874</u> 9 AGE last birthday <u>80</u> yr		10 USUAL OCCUPATION (Give kind of work done & rank most of working life even if retired) <u>Gardener landscape gardener</u> 11 KIND OF BUSINESS OR INDUSTRY <u>Gardener</u> 12 BIRTHPLACE (State or foreign country) <u>Germany</u> 13 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME: <u>BRUNO Bosse</u> 14 MOTHER'S MAIDEN NAME <u>JOSANNA</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>1</u> 16 SOCIAL SECURITY NO. <u>1</u>	
17 INFORMANT'S ADDRESS <u>MRS. Mary Benhoff same</u>		18 MEDICAL CERTIFICATION	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Bronchiopneumonia</u> ANTECEDENT CAUSE (B) <u>Advanced arteriosclerosis</u> DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Extreme Debility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>unknown</u>	
19A DATE OF OPERATION <u>5 17 1955</u> 19B MAJOR FINDINGS OF OPERATION		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner) 21B PLACE (Home, farm, factory, etc.) OF INJURY <u>Spring Grove St Hosp</u> 21C WHERE DID INJURY OCCUR? <u>at work</u>		21E INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> 21F HOW DID INJURY OCCUR?	
22 I hereby certify that I attended the deceased from <u>3 17 1955</u> to <u>5 17 1955</u> , that I last saw the deceased alive on <u>5 17 1955</u> , and that death occurred at <u>11:10 PM</u> from the causes and on the date stated above.			
23 BURIAL CREMATION REBURNAL (Specify) <u>Burial</u> DATE THEREOF <u>5/21/55</u> NAME OF CEMETERY OR CREMATORY, LOCATION (City or town or county) <u>Sacred Heart Balto Md</u> DATE PEC'D BY LOCAL REGISTRAR <u>5-18-55</u> REGISTRAR'S SIGNATURE <u>A W Pedraza</u> FUNERAL DIRECTOR <u>Leonard J. Ruck</u> ADDRESS <u>315 Bayview</u>		24 SIGNATURE OF PHYSICIAN <u>Gertfried Fleischmann</u> ADDRESS <u>Spring Grove St Hosp</u> DATE SIGNED <u>5 17 55</u>	



4366

CERTIFICATE OF DEATH

Reg. Dist No. 38

1 PLACE OF DEATH.

COUNTY Baltimore MARYLAND
 (CITY If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) in this place
 TOWN Rural: Towson 17 miles 10 mts. dyc.
 HOSPITAL OR
 INSTITUTION OR Eudowood Sanatorium
 STREET ADDRESS Towson 4, Maryland

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY L. f.
 (CITY If outside corporate limits write RURAL and give nearest town)
 OR
 TOWN Baltimore 21
 STREET ADDRESS (If rural give location)
1615 Rickenbacker Rd.

3 NAME OF DECEASED

(Type or Print) Dorothy

(First)

Ellis

(Middle)

Dreon

(Last)

4 DATE OF DEATH

(Month)

(Day)

(Year)

5181955

5. SEX.

6 COLOR OR RACE:

7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE (last birthday)

10. UNDER 1 YEAR 11. UNDER 24 HRS

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Homemaking

11 BIRTHPLACE (State or foreign country)

JuBois, Penn.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Alonzo D. Weaver

14. MOTHER'S MAIDEN NAME:

Myrtle Ellis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS

Personal HistoryHospital Records, Eudowood Sanatorium

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

II OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE Home, farm, factory, street, office bldg, etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-31, 1948 to 5-18, 1955, that I last saw the deceasedalive on 5-18, 1955, and that death occurred at 6:15 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. RURAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City and County)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 19, 1955Mabel C. GrayJohn Burns Lane, Towson, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are is especially important. Physicians with the causes of death clearly and legibly.



FORM NO. 1

1-1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4367

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04340

<p>1 PLACE OF DEATH</p> <p>COUNTY <u>Baltimore</u> MARYLAND</p> <p>CITY If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> LENGTH OF STAY (in this place) <u>68 Days</u></p> <p>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u></p>		<p>2 USUAL RESIDENCE HOME) OF DECEASED</p> <p>STATE <u>Maryland</u> COUNTY <u>Baltimore</u></p> <p>CITY If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u></p> <p>STREET ADDRESS (If rural give location) <u>3213 Abell Avenue</u></p>	
<p>3 NAME OF DECEASED (Type or Print) <u>OLIVER M. BROOKS</u></p> <p>4 SEX <u>Male</u> 5 COLOR OR RACE <u>White</u> 6 SINGLE MARRIED <u>Married</u> 7 DATE OF BIRTH <u>3/16/93</u></p>		<p>8 DATE (Month) Day (Year) OF DEATH <u>May 29, 1955</u></p> <p>9 AGE last birthday <u>62</u> yrs</p>	
<p>10a USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>Painter</u></p> <p>10b KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u></p>		<p>11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u></p> <p>12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u></p>	
<p>13 FATHER'S NAME <u>Leonard V. Brooks</u></p> <p>14 MOTHER'S MAIDEN NAME <u>Elizabeth Cook</u></p>		<p>15 INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u></p>	
<p>16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If Yes, give war or dates of service <u>WW I</u></p> <p>17 SOCIAL SECURITY NO <u>214 - 22 - 2018</u></p>		<p>18 MEDICAL CERTIFICATION</p> <p>19 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>IMMEDIATE CAUSE (A) <u>CARCINOMA OF RIGHT LUNG</u></p> <p>ANTECEDENT CAUSE (B) <u>Unknown</u></p>	
<p>20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</p>		<p>21 DATE OF OPERATION <u>2</u></p> <p>22 MAJOR FINDINGS OF OPERATION</p>	
<p>23a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)</p> <p>23b TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M</p>		<p>23c PLACE (Home, farm, factory, street, office, etc.) OF INJURY</p> <p>23d WHERE DID INJURY OCCUR? City or town County State</p>	
<p>24 I hereby certify that I attended the deceased from <u>Mar. 22, 1955</u> to <u>May 29, 1955</u> and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.</p> <p>SIGNATURE <u>William B. Vandegrift</u> ADDRESS DATE SIGNED <u>5/30/55</u></p>		<p>25 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>June 2, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> LOCATION (City, town, or county) <u>Baltimore, Maryland</u></p>	
<p>26 DATE REC'D BY LOCAL REGISTRAR <u>6-1-55</u> REGISTRAR'S SIGNATURE <u>W. B. Vandegrift</u></p>		<p>27 FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Blight Inc. 6009 Harford Rd., Baltimore, Md., Maryland</u></p>	



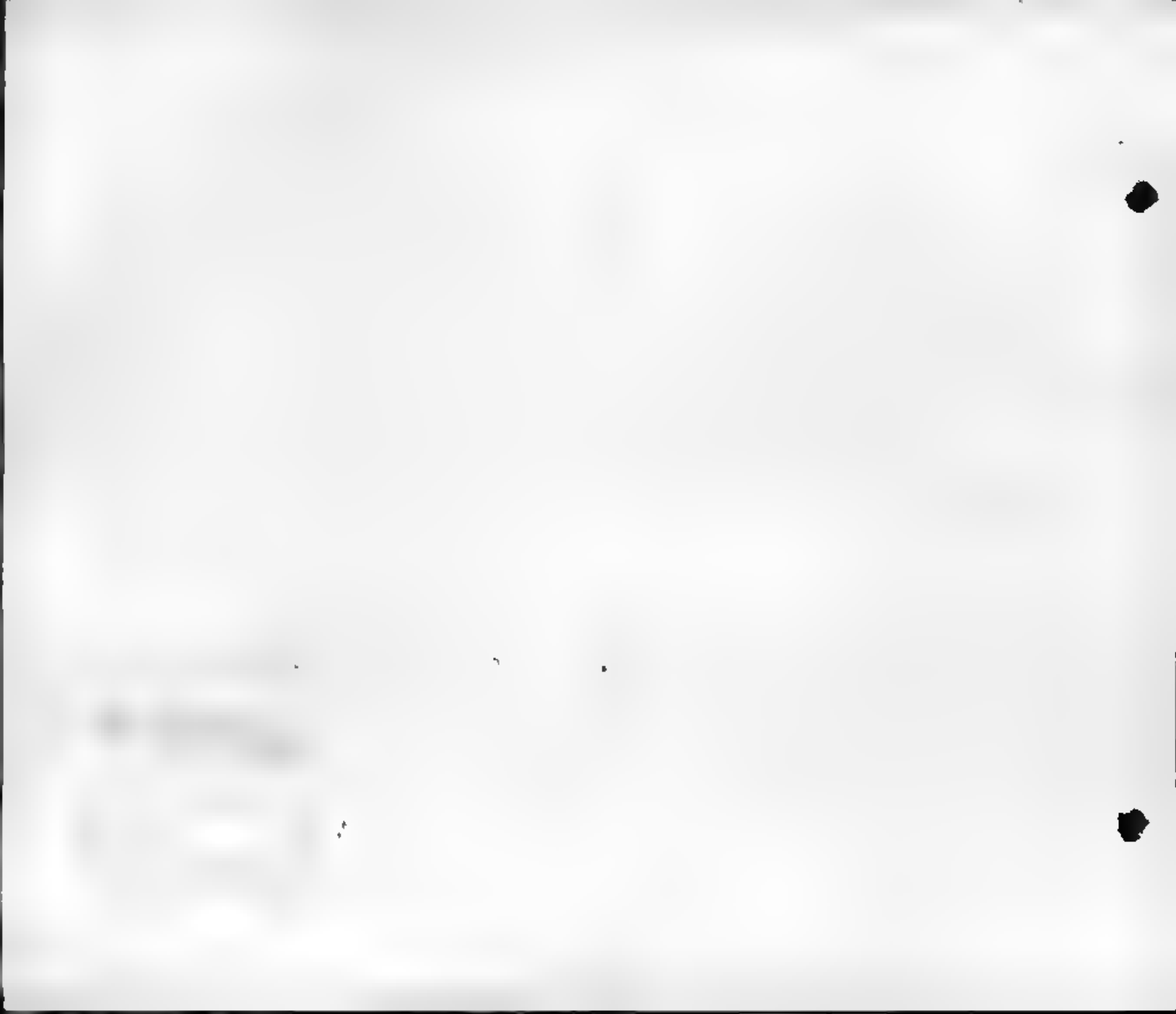
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04341

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1 PLACE OF DEATH COUNTY BALTIMORE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE SINCE 1/7/49 OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRING-GROVE		2 USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY ANNE ARUNDEL CITY (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS OR TOWN STREET ADDRESS (If rural give location) 45 MADISON AVE	
3 NAME OF DECEASED Type or Print BENJAMIN B. BROWN		4 DATE (Month) (Day) (Year) OF DEATH 5 8 1955	
5 SEX M 6 COLOR OR 7 SINGLE MARRIED WIDOWED DIVORCED W 8 DATE OF BIRTH 6/6/78		9 AGE last birthday 76 yrs Months Days Hours Min.	
10A USAL OCCUPATION (Give kind of work done during most of working life even if retired) PLASTERER		10B KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME Robert W. Brown		14 MOTHER'S MAIDEN NAME ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or ink (If Yes, give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMATION & ADDRESS HOSPITAL RECORDS			
18. MEDICAL CERTIFICATION 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 493X IMMEDIATE CAUSE ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) PNEUMONIA DUE TO (B) DUE TO (C)	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH EPILEPSY, ARTERIOSCLEROSIS		YEARS	
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, note medical examiner.)		21B PLACE (Home, farm, factory, etc.) OF INJURY Home	
21C WHERE DID INJURY OCCUR? (County) (State)			
22. I hereby certify that I attended the deceased from 7/7/49 , 19 50A , to 5/8/55 , 19 55 , that I last saw the deceased alive on 5/8/55 , 19 55 , and that death occurred at MD Spring Grove Hosp. on the date stated above.			
23 BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5-10-55	
NAME OF CEMETERY OR CREMATORY St. James Cemetery		LOCATION (City or town) (County) (State) Annapolis	
DATE REC'D BY LOCAL REGISTRAR May 9, 1955		REGISTRAR'S SIGNATURE Victor E. Harris	
FUNERAL DIRECTOR John W. Taylor		ADDRESS Suit 1000	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **04342**
CERTIFICATE OF DEATH Reg. Dist. No. **38**

4369

1 PLACE OF DEATH

COUNTY **Balto.** MARYLAND
 CITY (If outside corporate limits, write RURAL) LENGTH OF STAY
 OR (If outside corporate limits, write RURAL and give nearest town)
 TOWN **Baltimore** (In this place)
 HOSPITAL OR INSTITUTE ON OR STREET ADDRESS **Armecost Nursing Home**
812 Regester Ave.

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE **MD.** COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN **Baltimore**
 STREET ADDRESS (If rural, give location)
Wyman Park Apts.

3 NAME OF DECEASED
 (Type or Print)

First (Middle) (Last)
WALTER B. CALLOWAY

4 DATE OF DEATH (Month) (Day) (Year)

May 13, 1955

5 SEX

male

6 COLOR OR RACE

white

7 SINGLE MARRIED

WIDOWED

8 DATE OF BIRTH

Dec. 28, 1873

9 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS

81 Months Days Hours Min

10A USUAL OCCUPATION (Give kind of work done if regular, or even if retired)

Gen'l Passenger Traffic Mg.

10B KIND OF BUSINESS OR INDUSTRY

-RR

11 BIRTHPLACE (State or foreign country)

Ohio

12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME

Thomas Bond Calloway

14 MOTHER'S MAIDEN NAME

Anna Bowles

15 WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16 SOCIAL SECURITY NO.

no

17 INFORMANT'S ADDRESS

Mr. A. B. Calloway - Wyman Park Apts.

18 MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

473X

IMMEDIATE CAUSE

(A)

Emphysema

ANTECEDENT CAUSE (B)

DUE TO

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE

(B)

DUE TO

STATING UNDERLYING CAUSE LAST

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

Central Vacuoles accident

INTERVAL BETWEEN ONSET AND DEATH

4 days

19A DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21B PLACE (If home, farm, factory, street, office bldg, etc.)

21C WHERE DID INJURY OCCUR?

21D TIME (Month) (Day) (Year) (Hour)

OF INJURY

21E INJURY OCCURRED

While at work ☐ Not while at work ☐

21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/23/49 to 5/13/55, 19, that I last saw the deceased

alive on 5/12/55, 19, and that death occurred at 5 A M, from the causes and on the date stated above

SIGNATURE

Francis W. Bluer

ADDRESS

100 W. University Pkwy

DATE SIGNED

5/14/55

23 BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

5/16/55

NAME OF CEMETERY OR CREMATORY

Glen Forest Cem.

LOCATION (City or town or county)

Harrison, Ohio

DATE REC'D BY LOCAL REGISTRAR

May 14 1955

REGISTRAR'S SIGNATURE

R.W.

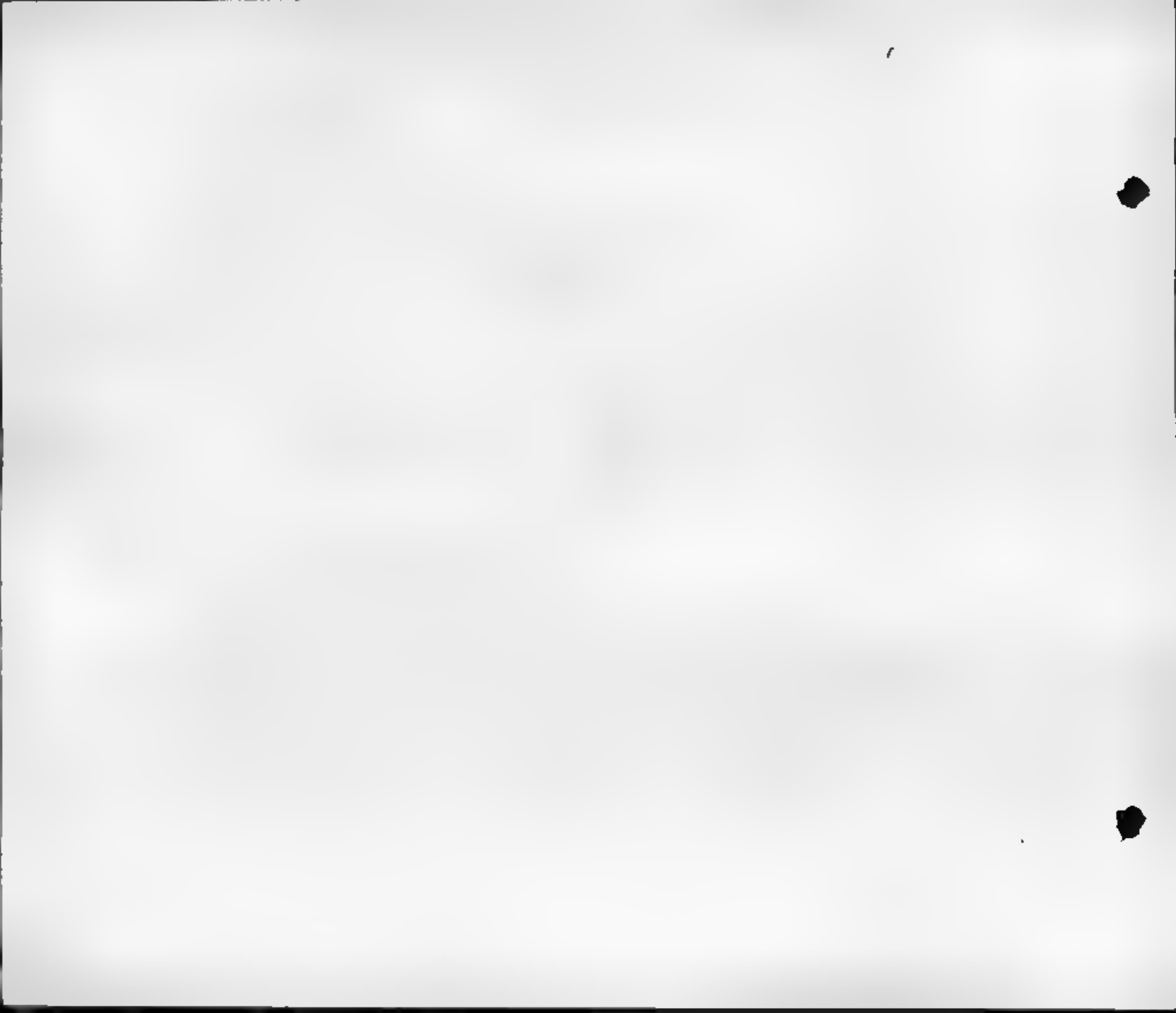
FUNERAL DIRECTOR

Thos. J. Dickener & Sons - Balto 17

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4370

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04343

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND	CITY <u>Baltimore</u> RURAL <u>114 days</u> LENGTH OF STAY <u>114 days</u>	STATE <u>MD</u> COUNTY <u>Baltimore</u>	CITY <u>Baltimore</u> RURAL <u>114 days</u> LENGTH OF STAY <u>114 days</u>
TOWN <u>114 days</u>	HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>114 days</u>	STREET ADDRESS <u>4106 Newton Road</u>	
3 NAME OF DECEASED (Type or Print)	4 DATE (Month) (Day) (Year)	5 AGE last birthday	
<u>John A. White</u>	<u>5-9-1955</u>	<u>48</u>	
6 SEX <u>Male</u>	7 SINGLE <u>Married</u>	8 DATE OF BIRTH	
9 CC OR OR 7 SINGLE <u>Married</u>	10 WIDOWED <u>Divorced</u>	11 BIRTHPLACE (State or foreign country)	
12 USUAL OCCUPATION (Give kind of work done during the last working life even if retired)	13 KIND OF BUSINESS OR INDUSTRY	14 CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>	<u>Unknown</u>	<u>Unknown</u>	
15 FATHER'S NAME	16 MOTHER'S MAIDEN NAME	17 INFORMANT & ADDRESS	
<u>Unknown</u>	<u>Unknown</u>	<u>Mr. Samuel J. White - 4106 Newton Road</u>	
18 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	19 SOCIAL SECURITY NO	20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>No</u>	<u>Unknown</u>		
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>422.1</u>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(A) <u>Cerebrovascular accident</u>			
DUE TO			
(B) <u>Chronic degenerative cerebrovascular disease</u>			
DUE TO			
(C) <u>Generalized arteriosclerosis</u>			
21 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
22 DATE OF OPERATION		23 MAJOR FINDINGS OF OPERATION	
<u>5-10-55</u>		<u>Resection of tumor</u>	
24 ACCIDENT WAS UNEXPECTED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)		25 PLACE, HOME, FARM, FACTORY, OFFICE BLDG, ETC. WHERE DID INJURY OCCUR?	
<u>Yes</u>		<u>Home</u>	
26 TIME (Month) (Day) (Year) (Hour) OF INJURY		27 INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<u>5-9-55</u>		<u>While at work</u>	
28 I hereby certify that I attended the deceased from <u>5-2-55</u> to <u>5-9-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-9-55</u> , 19 <u>55</u> , and that death occurred at <u>4:45</u> M from the causes and on the date stated above.		29 WHERE DID INJURY OCCUR? City or town (County) (State)	
SIGNATURE <u>John A. White</u>		<u>Baltimore</u> <u>MD</u>	
30 BURIAL CREMATION REMOVAL (SPECIFY)		31 NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Greenwood</u>	
DATE PEC'D BY LOCAL REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harris</u>	
32 FUNERAL DIRECTOR		33 ADDRESS	
<u>Jack Keweenaw</u>		<u>2100 Canton Rd</u>	

4371

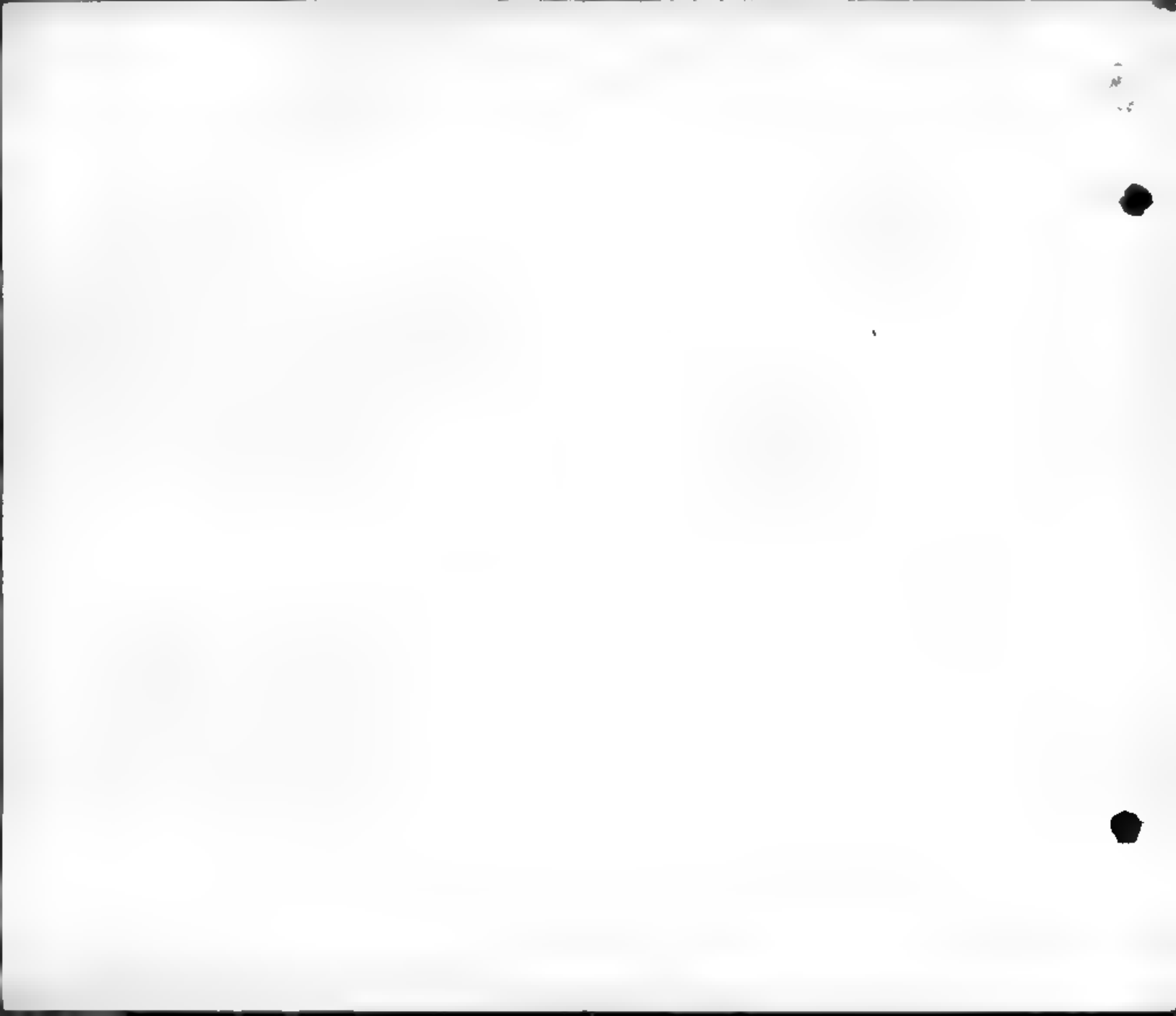
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>Baltimore</u>			
CITY <u>Oliver Beach</u> (If outside corporate limits, write RURAL and give nearest town)				CITY <u>Oliver Beach</u> (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Oliver Beach</u> (In this place)				TOWN <u>Oliver Beach</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gunpowder Rd.</u>				STREET ADDRESS (If rural give location) <u>Gunpowder Pl.</u>			
3 NAME OF DECEASED (First) (Middle) (Last) <u>Bessie M. CASSELL</u>				4 DATE (Month) (Day) (Year) OF DEATH <u>May 19 1955</u>			
5 SEX <u>F.</u>		6 COLOR OR RACE <u>W.</u>		7 SINGLE MARRIED WIDOWED DIVORCED <u>Married</u>		8 DATE OF BIRTH <u>May 1, 1888</u>	
9 AGE last birthday <u>67</u> yrs		10 MONTHS <u>6</u> DAYS <u>19</u> HOURS <u>19</u> MIN.		9 AGE last birthday (If under 24 hrs)		10 MONTHS <u>6</u> DAYS <u>19</u> HOURS <u>19</u> MIN.	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11 BIRTHPLACE (State or foreign country) <u>Md.</u>				12 CITIZEN OF WHAT COUNTRY? <u>—</u>			
13 FATHER'S NAME <u>Albert Elsroad</u>				14 MOTHER'S MAIDEN NAME <u>Victoria Hahn</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or pri.) (If Yes, give way or dates of service) <u>no</u>				16 SOCIAL SECURITY NO <u>none</u>			
17 INFORMANT & ADDRESS <u>Miller B. Cassell Oliver Beach, Md.</u>				18 MEDICAL CERTIFICATION			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>3 DAYS</u>			
ANTECEDENT CAUSE (B) <u>Cerebral Injury—Accident Nov. 1954</u>				<u>6 Mo.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				(C) <u>DIABETES Mell. Ins.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, not by medical examiner)		21b PLACE (Home, farm, factory, street, office bldg. etc.)		21c WHERE DID (City or town) (County) (State)			
21d TIME (Month) (Day) (Year) OF INJURY <u>M</u>		21e INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAR 1955</u> , to <u>MAY 19, 1955</u> , that I last saw the deceased alive on <u>May 19, 1955</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Oliver</u>		LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>—</u>		24 FUNERAL DIRECTOR <u>M.R. Etchison & Son</u>		ADDRESS <u>Frederick, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4372

CERTIFICATE OF DEATH

Reg Dist No.

1 PLACE OF DEATH:		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write OR and give nearest town) <u>PARKVILLE</u>	RURAL/LENGTH OF STAY (in this place) <u>2 years</u>	CITY (If outside corporate limits, write OR and give nearest town) <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7834 DANIEL AVE</u>		STREET ADDRESS (If rural give location) <u>7834 DANIEL AVE</u>	
3 NAME OF DECEASED: (First) <u>Theodore</u> (Middle) <u>Chop</u> (Last) <u>Chop</u>		4 DATE OF DEATH Month <u>May</u> Day <u>25</u> (Year) <u>1955</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8 DATE OF BIRTH: <u>JAN 23 - 1916</u>
9 AGE last birthday <u>39</u> yrs		10 UNDER 1 YEAR If UNDER 1 YEAR: Months <u>25</u> Days <u>19</u> Hours <u>55</u> Min	
11a USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Electronics Tech</u>		11b KIND OF BUSINESS OR INDUSTRY: <u>Penn</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME: <u>FRANK Chop</u>	
14 MOTHER'S MAIDEN NAME: <u>MARY ZNIDARSK</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>Yes</u> (If Yes give war or dates of service) <u>II</u>	
16 Social Security No. <u>172-03-2886</u>		17 INFORMANT & ADDRESS: <u>M Dolores Chop 7834 DANIEL AVE</u>	
18. MEDICAL CERTIFICATION			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
(a) Immediate cause <u>Acute Myocarditis with Congestive heart failure</u>		<u>6 mos.</u>	
(b) Antecedent causes (c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>Cardiac Hypertrophy</u>		<u>12 mos.</u>	
<u>In malignant Hypertension</u>		<u>15 mos.</u>	
<u>Idiopathic Hypertension</u>		<u>7 yrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>None</u>			
19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office, bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 24, 1955</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
Signature of Physician <u>Frank A. Kasik, M.D.</u>		ADDRESS <u>9005 HARFORD RD BALTO 14</u> DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>MAY 30 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Johnston</u>		LOCATION (City, town, or county) (State) <u>Penn</u>	
DATE REC'D BY LOCAL REGISTRAR <u>26 55</u>		REGISTRAR'S SIGNATURE <u>Chas. F. Evans & Son</u>	
24. FUNERAL DIRECTOR <u>Chas. F. Evans & Son</u>		ADDRESS <u>6802 HARFORD RD</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04346

30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Catonsville Nursing Home</u>		STREET ADDRESS (If rural give location) <u>315 Ingelside Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>A.</u>	(Last) <u>Christ</u>
4. SEX <u>Male</u>	5. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 27, 1892</u>
9. AGE last birthday <u>62</u> yrs.		10. DATE OF DEATH <u>May 29, 1955</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Christ</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-4736</u>	
17. INFORMANT AND ADDRESS <u>Mrs Anna Woelfer 577 47th Street</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
<p>4. Immediate cause (a) <u>Chronic Myocardial Degeneration 1 year.</u></p> <p>Antecedent cause(s) (b) <u>Arteriosclerotic Cardiovascular Disease 3 yrs.</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Parkinson's Disease 6 yrs.</u></p>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19. DATE OF OPERATION <u>No operation</u>	20. MAJOR FINDINGS OF OPERATION
21. ACIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, (arm, factory, street, office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 23, 1953</u> , to <u>May 29, 1955</u> , that I last saw the deceased alive on <u>May 23, 1955</u> , and that death occurred at <u>A. M.</u> from the causes and on the date stated above	
SIGNATURE <u>Joshua H. Armacoist M.D.</u>	ADDRESS <u>6419 W. Windsor Mill Rd Baltimore 7 Md Md</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 1, 1955</u>
NAME OF CEMETERY OR CREMATORY <u>Schwartz</u>	LOCATION (City, town, or county) (State) <u>Baltimore</u>
DATE REC'D BY LOCAL REG. <u>5-31-55</u>	24. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc., 103 S. Wolfe St.</u>



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04347

4374

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Catonsville</u> TOWN HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Welcome</u> TOWN STREET ADDRESS (If rural give location)	
3 NAME OF DECEASED (Type or Print) <u>William Brent Clements</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>May 4, 19 55</u>	
5 SEX <u>Male</u> 6 COLOR OR RACE <u>White</u> 7 SINGLE MARRIED <u>Widowed</u> 8 DATE OF BIRTH <u>3-27-1874</u>		9 AGE last birthday <u>80</u> 10 MONTHS <u>0</u> 11 DAYS <u>0</u> 12 HOURS <u>0</u> 13 MIN <u>0</u>	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Blacksmith</u>		10B KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME <u>Alonzo</u>		14 MOTHER'S MAIDEN NAME <u>Mary A. Richardson</u>	
15 WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service) <u>Unknown</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17 INFORMANT & ADDRESS <u>Records Spring Grove State Hospital</u>		18 MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
592K IMMEDIATE CAUSE (A) <u>Chronic nephritis</u> ANTECEDENT CAUSE (B) <u>Due to</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Due to</u>		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Banti's Syndrome</u>		Years	
19A DATE OF OPERATION <u>2</u>		19B MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory, office bldg, etc.) OF INJURY	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E INJURY OCCURRED While at work Not while at work		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4-30-1955</u> to <u>5-4-1955</u> that I last saw the deceased alive on <u>5-4-1955</u> , and that death occurred at <u>9:20AM</u> , from the causes and on the date stated above			
SIGNATURE <u>Spring Grove State Hosp</u>		ADDRESS <u>Catonsville 28, Md.</u> DATE SIGNED <u>5-4-55</u>	
23 BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>5-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Charles Cemetery</u> LOCATION (City or town) (County) (State) <u>Hylymont, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>		24 FUNERAL DIRECTOR <u>Hunt & Ryan</u> ADDRESS <u>Waldorf, Md.</u>	



4375

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 14348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30

1. PLACE OF DEATH:

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

Catonville

LENGTH OF STAY (In this place)

10-24-53

TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Spring Hill Hosp

3. NAME OF DECEASED: (Type or Print)

Katherine Ruth Coates

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

W

8. DATE OF BIRTH:

9-13-73

4. DATE OF DEATH

5-7-53

9. AGE last birthday:

81

IF UNDER 1 YEAR: Months Days Hours Min.

10a. USAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

Md

12. CITIZEN OF WHAT COUNTRY:

USA

13. FATHER'S NAME:

AMOS

14. MOTHER'S MAIDEN NAME:

Marion Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS:

Hosp Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

7-7

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

Acute Cardiac failure
terminal Pneumonia
fracture left hip

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

May 5 53

19b. MAJOR FINDING OF OPERATION:

Hip fracture corrected by pin

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

□

21. PLACE Home, farm, factory, OF street, office bldg, etc., INJURY

21c. (City or town), County)

Catonville Baltimore Md

20. AUTOPSY?

Yes ☐ No ☒

21a. TIME Month) (Day) (Year) (Hour) OF INJURY

3

24

53

M

21b. INJURY OCCURRED While at work ☐ Not while at work ☒

21c. HOW DID INJURY OCCUR?

fall on floor

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

J. H. Kieffer

1010 Leaden

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

5-8-53

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/10/55

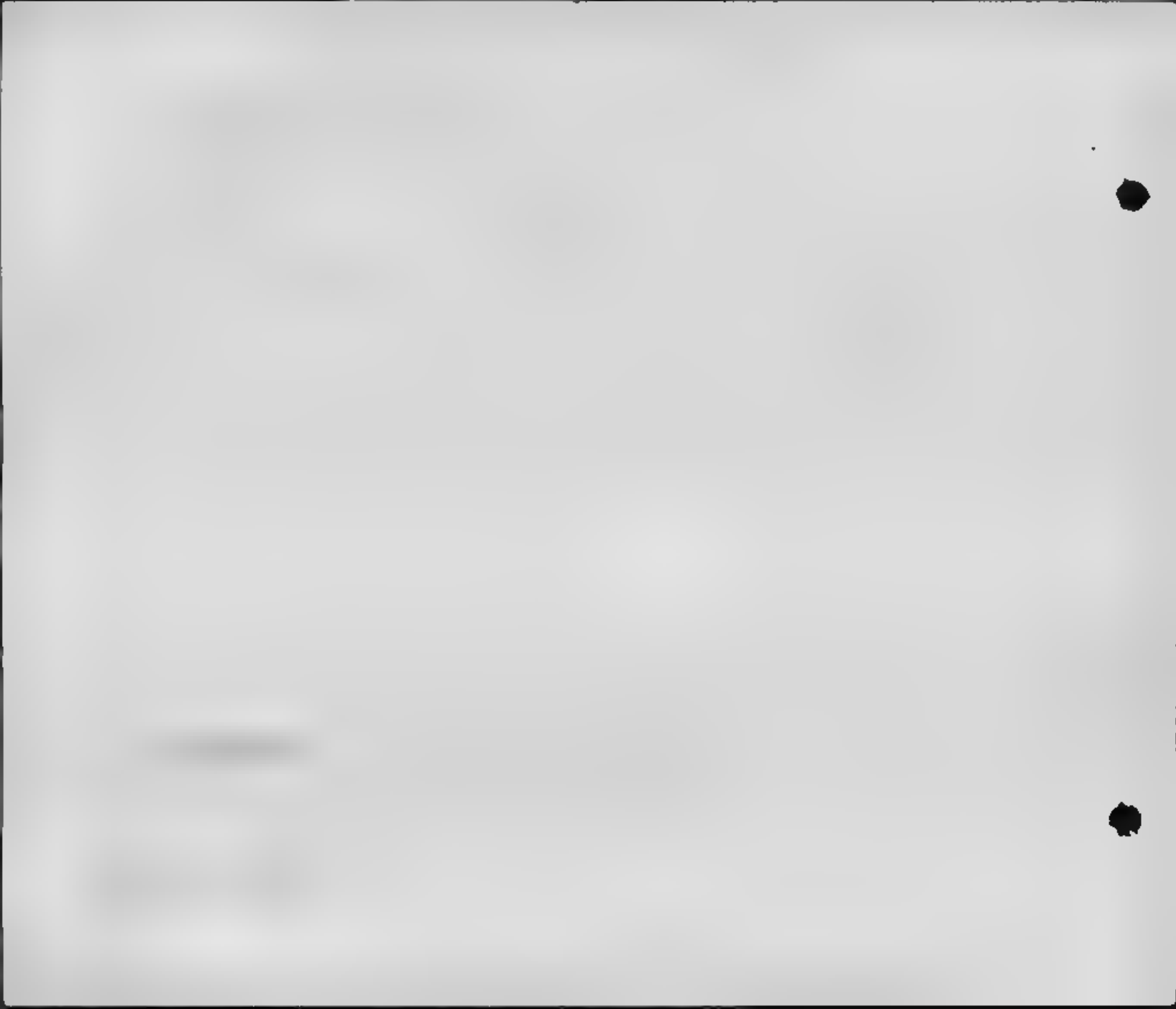
W. E. Harris

B. W. Smith & Son

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53



4376

CERTIFICATE OF DEATH

Reg Dist No

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>158 Dumbarton Road</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>158 Dumbarton Road #12</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mr. Benjamin F. Collier</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>May 31st 1955</u>	
5 SEX <u>male</u> 6 COLOR OR RACE <u>white</u> 7 SINGLE MARRIED WIDOWED DIVORCED (Specify) <u>widowed</u> 8 DATE OF BIRTH <u>Sept. 22, 1888</u> 9 AGE last birthday <u>66</u> yrs IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		11 BIRTHPLACE (State or foreign country) <u>Virginia</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Packer Rice Bakery</u> 10B KIND OF BUSINESS OR INDUSTRY		13 FATHER'S NAME: <u>Mr. Charles H. Collier</u> 14 MOTHER'S MAIDEN NAME <u>Catherine V. Coats</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>215-01-0999</u> 16 SOCIAL SECURITY NO		17 INFORMANT'S ADDRESS <u>Mrs. Gustav Klein, 158 Dumbarton Road #12</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>150X</u> IMMEDIATE CAUSE (A) <u>Cocaine of morphine abuse</u> ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>Opia 1554/11</u> 19B MAJOR FINDINGS OF OPERATION <u>As above</u>		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory or INJURY street office bldg etc) 21C WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u> 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 30, 1955</u> , to <u>May 31, 1955</u> , that I last saw the deceased alive on <u>May 30, 1955</u> , and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Henry H. H. H. H. H.</u> ADDRESS <u>M D 418 North D. Baltimore, Md.</u> DATE SIGNED			
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>June 3, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		24 FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, 5305 Harford Road #12</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-1-55</u> REGISTRAR'S SIGNATURE <u>R. W. H. H. H.</u>			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Haase

4218 Harvard

MARYLAND, STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04350

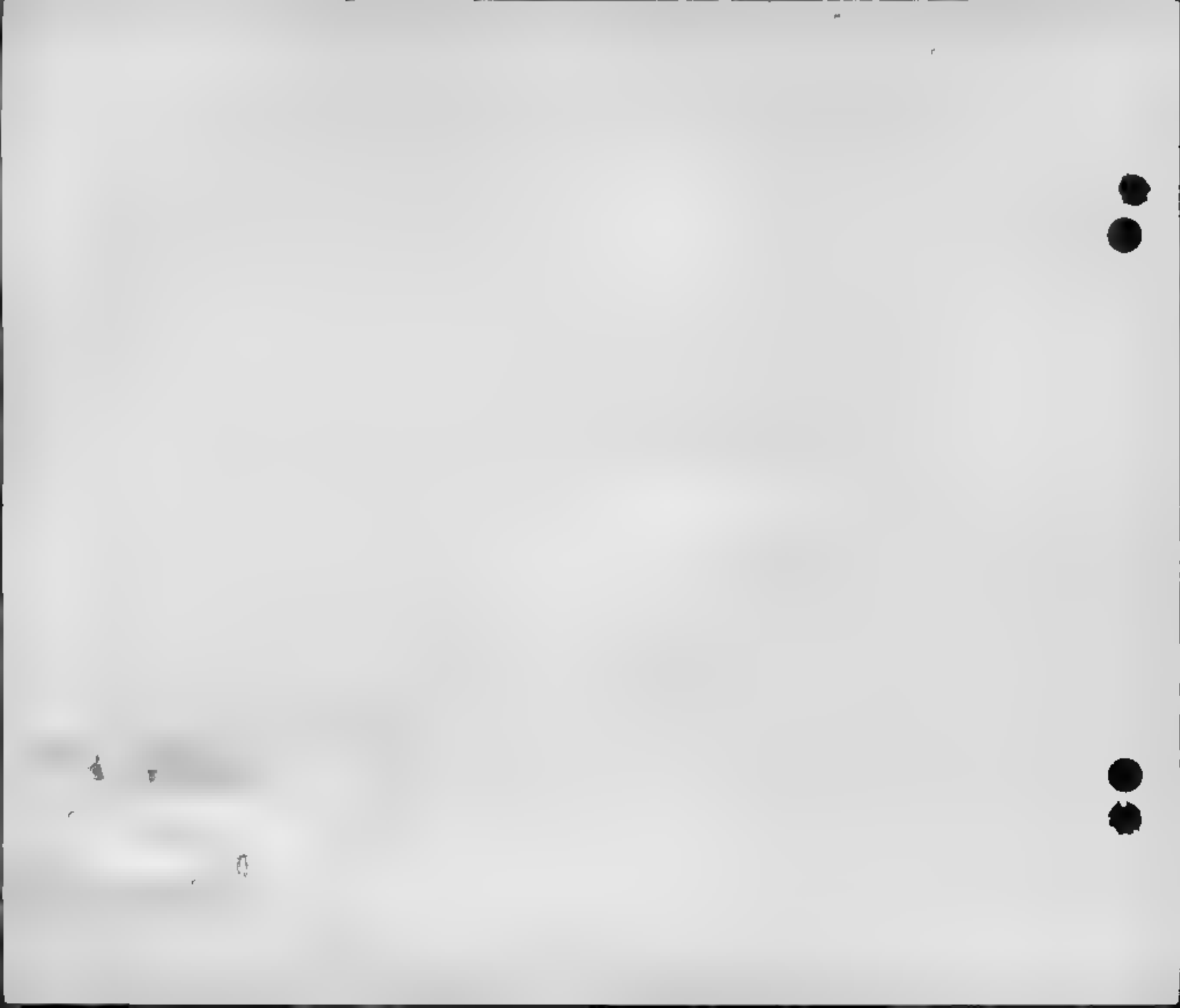
Reg. Dist. No. 35

4377

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE HOME OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Parkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rayville Rd.</u>		STREET ADDRESS <u>Rayville Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>HARRY CLIFTON COOPER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 13 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 26 1892</u>
9. AGE last birthday <u>62</u> yrs.		10. CITIZENSHIP <u>U.S.A.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
12. BIRTHPLACE (State or foreign country) <u>Parkton Md. B.S.</u>		13. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. FATHER'S NAME <u>James Cooper</u>		15. MOTHER'S MAIDEN NAME <u>Clara Armacost</u>	
16. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>-</u>	
18. INFORMANT AND ADDRESS <u>Mrs. Sydney Cotter, Parkton, Ind.</u>		19. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>42</u> Immediate cause (a) <u>Coronary occlusion</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
22. FATALITY CAUSE WAS PRIMARY OR CONTRIBUTING - PLACE (Home, farm, factory, street, office, hotel, etc.) OF INJURY TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED (a) INJURY (b) <u>Work</u> (c) <u>Not at work</u>		(CITY OR TOWN) (COUNTY) (STATE)	
23. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes, accident, suicide, homicide, or undetermined.		24. DATE SIGNED <u>5/13/53</u>	
SIGNATURE <u>A. M. France M.D.</u>		ADDRESS <u>Parkton Ind.</u>	
25. BURIAL CREMATION (Burial) <u>Burial</u> DATE THE BODY <u>May 16 1953</u>		NAME OF CEMETERY OR CREMATORY <u>Pine Grove F.B. Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Parkton Balto. Co. Md.</u>		26. FUNERAL DIRECTOR <u>James H. Hertenstein, New Freedom, Pa.</u>	
DATE REC'D BY LOCAL HEALTH OFFICER <u>May 19 1953</u>		SIGNATURE OF LOCAL HEALTH OFFICER <u>Charles E. Gaudin</u>	

MARGIN RESERVED FOR BINDING



F. The

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE INK—DO NOT USE A BALL POINT PEN.

Every item of information see carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be with the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

4378

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, film 181 5-20-55

CERTIFICATE OF DEATH

Reg. Dist. No.

0435130

1 NAME OF DECEASED (Type or Print) <u>JANE COOPER</u>			2. DATE OF DEATH <u>5/11/55</u>		
3 PLACE OF DEATH a Baltimore City, Maryland <u>Baltimore City</u>			4 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a STATE <u>Scranton PA</u> b COUNTY <u>Scranton</u>		
b FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City</u>			c CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore (Catonville)</u>		
c Length of stay in Baltimore <u>5 weeks</u>			d STREET ADDRESS (If rural, give location) <u>516 Madison Ave - L.A.M.</u>		
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE MARRIED WIDOWED DIVORCED (Specify) <u>Married</u>	8 DATE OF BIRTH <u>1892</u>	9 AGE (In year last birthday) <u>63</u>	10 Under 1 Year Months Days Hours Min. <u>5 8</u>
10a USUAL OCCUPATION (Occupation of work done during most of working life, even if retired) <u>Machine Operator</u>			10b KIND OF BUSINESS OR INDUSTRY <u>Machine</u>		
11 BIRTHPLACE (State or foreign country) <u>Scranton PA</u>			12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13 FATHER'S NAME <u>David Hughes</u>			14 MOTHER'S MAIDEN NAME <u>Susan White</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			16 SOCIAL SECURITY NO <u>204-12-3811</u>		
17 INFORMANT <u>Thema Cooper</u>			ADDRESS <u>516 Madison Ave</u>		
18. <u>174X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO <u>Pulmonary Embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST DUE TO <u>General Peritonitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 Mts</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT DUE TO <u>Chronic Rheumatism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Mts</u>		
19a DATE OF OPERATION <u>5/12/55</u>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Chronic Rheumatism</u>		
20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21 HOW DID INJURY OCCUR? <u>While at work</u>		
22 I certify that (I) (this hospital) attended the deceased from <u>5/12/55</u> to <u>5/13/55</u> , that (I) (we) last saw the deceased alive on <u>5/11/55</u> , and that death occurred at <u>6:50 a.m.</u> , from the causes and on the date stated above.			23a SIGNATURE <u>James H. Heston</u> M.D.		
23b ADDRESS <u>4123 Frederick Ave</u>			23c DATE SIGNED <u>5/13/55</u>		
24a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			24b DATE <u>5/16/55</u>		
24c NAME OF CEMETERY OR CREMATORY <u>Scranton PA</u>			24d LOCATION (City, town, or county) (State) <u>Scranton PA</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>5-13-55</u>			REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>		
25 FUNERAL DIRECTOR <u>W. H. Hedrick</u>			ADDRESS <u>1614 Hollens St</u>		

ML CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04352

4379

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH— COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overylaan</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overylaan</u>	
10. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>30 E Elm Ave</u>		STREET ADDRESS (If rural, give location) <u>30 E Elm Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna Catherine Capeland</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 12-1883</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired, <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Balto City Md</u>
13. FATHER'S NAME <u>Stein</u>		14. MOTHER'S MAIDEN NAME <u>Helen Hamann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Mr J. P. Capeland, 30 E Elm Ave</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>4 yrs</u>
(a) Immediate cause <u>Coronary Occlusion</u>		
(b) Antecedent cause(s) <u>Arteriosclerotic Cardiovascular disease</u>		
(c) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		

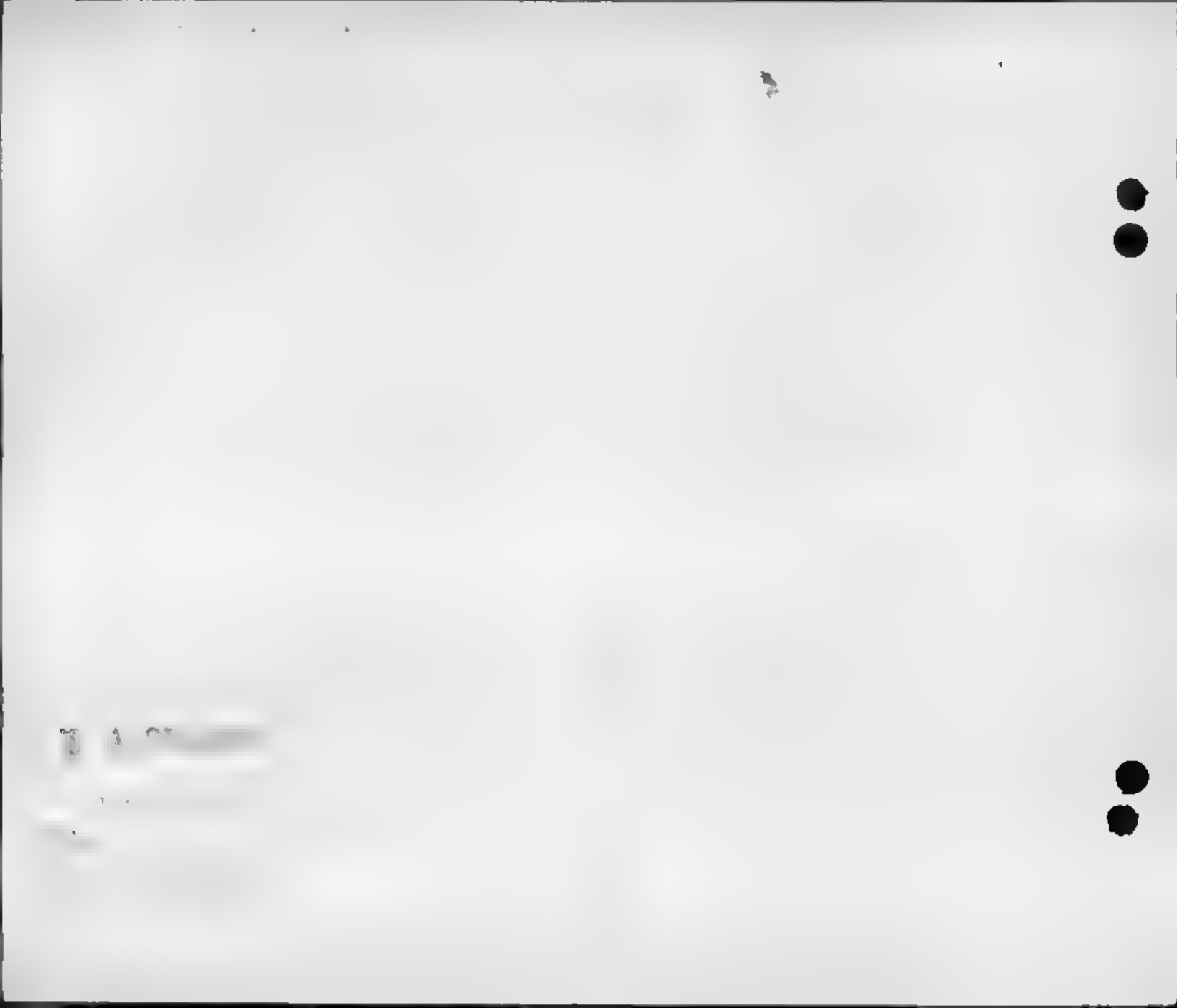
14. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) FALL HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, office bldg, etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 1, 1955, March 7, 1955, that I last saw the deceased alive on 5/7 1955, and that death occurred at 11:30 P m, from the causes and on the date stated above.

SIGNATURE <u>Dr. J. P. Capeland MD</u>		DATE SIGNED <u>5/9/55</u>	
23. BURIAL, CREMATION OR MOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>	
LOCATION (City, town, or county) <u>Balto Md</u>		(State)	
DATE REC'D BY LOCAL REG <u>May 9, 1955</u>	REGISTRAR'S SIGNATURE <u>Ann M. E. Reifsnider</u>	24. FUNERAL DIRECTOR <u>Lassiter Funeral Home</u>	ADDRESS <u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully The correct age is especially important. Physicians please write the causes of death clearly and legibly



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

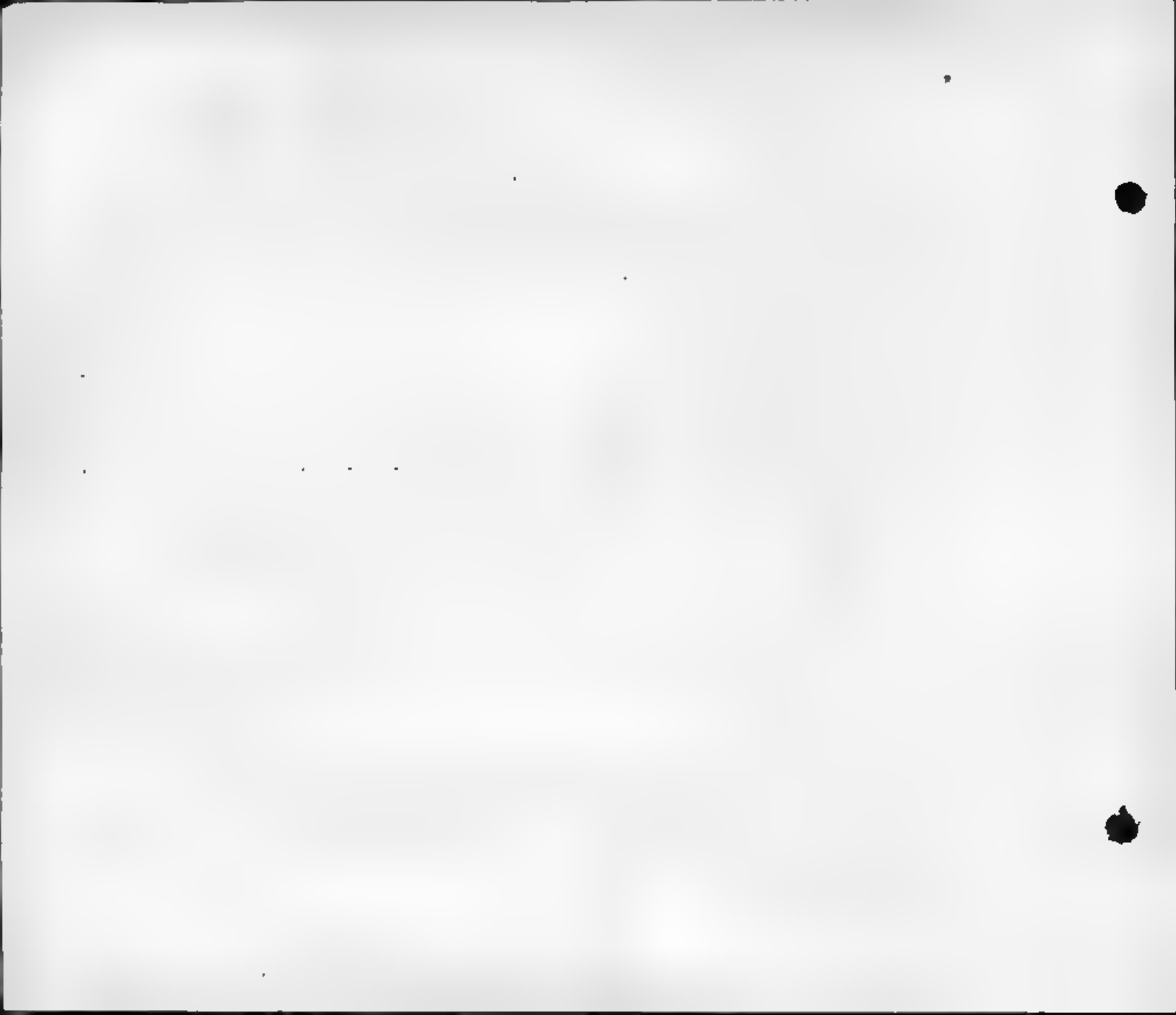
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04353

CERTIFICATE OF DEATH

Reg Dist. No. *18*

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY BALTIMORE CITY (If outside corporate limits write RURAL, and give nearest town) OR TOWN FORT HOWARD	MARYLAND LENGTH OF STAY 13 HRS. 40 MIN.	STATE MARYLAND COUNTY CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN BALTIMORE	STREET ADDRESS (If rural give location) 8219 BELAIR ROAD
3 NAME OF DECEASED (First) (Middle) (Last) SILAS A. DANIELS		4 DATE (Month) (Day) (Year) DEATH MAY 11 19 55	
5 SEX MALE RACE WHITE 6 CO OR OR 7 SINGLE MARRIED WIDOWED DIVORCED (Specify) MARRIED		8 DATE OF BIRTH 5-11-95 9 AGE last birthday 59 vs. Months Days Hours Min	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) WATC MAN		10B KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME JAMES DANIELS		14 MOTHER'S MAIDEN NAME ELIZA MN: UNKNOWN	
11 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of dates of service) YES WW I		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
15 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4201 IMMEDIATE CAUSE ANTECEDENT CAUSE (S)		16 SOCIAL SECURITY NO. 212-20-8030	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		17 INFORMANT'S ADDRESS CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		18 MEDICAL CERTIFICATION (A) OLD MYOCARDIAL INFARCTS, LEFT VENTRICLE (B) DUE TO CORONARY ARTERIOSCLEROSIS WITH THROMBOSIS (C) UNKNOWN	
19A DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either not by medical examination)		21B PLACE (If home, farm, factory or office bldg. etc.) OF INJURY	
21C WHERE D.D. (City or town) (County) (State) 10:50 A.M. 2:30 P.M.		21D TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E INJURY OCCURRED (While at work) (Not while at work)		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from MAY 11 19 55 to MAY 11 19 55 and that death occurred at 2:30 P.M. from the causes and on the date stated above			
SIGNATURE William B. VandeGriff, M.D.		DATE SIGNED 5-12-55	
23 REMOVAL (SPECIFY) MAY 14, 1955		NAME OF CEMETERY OR CREMATORY VILLA MARIA CEMETERY	
24 FUNERAL DIRECTOR Wm. Cook-Blight, Inc. Funeral Home		LOCATION (to town or county) BALTIMORE (TOWSON) MARYLAND	
25 DATE RECD BY LOCAL REGISTRAR 5-13-55		26 REGISTRAR'S SIGNATURE A.W. Hedger	



MARYLAND STATE DEPARTMENT OF HEALTH

04354

4343

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

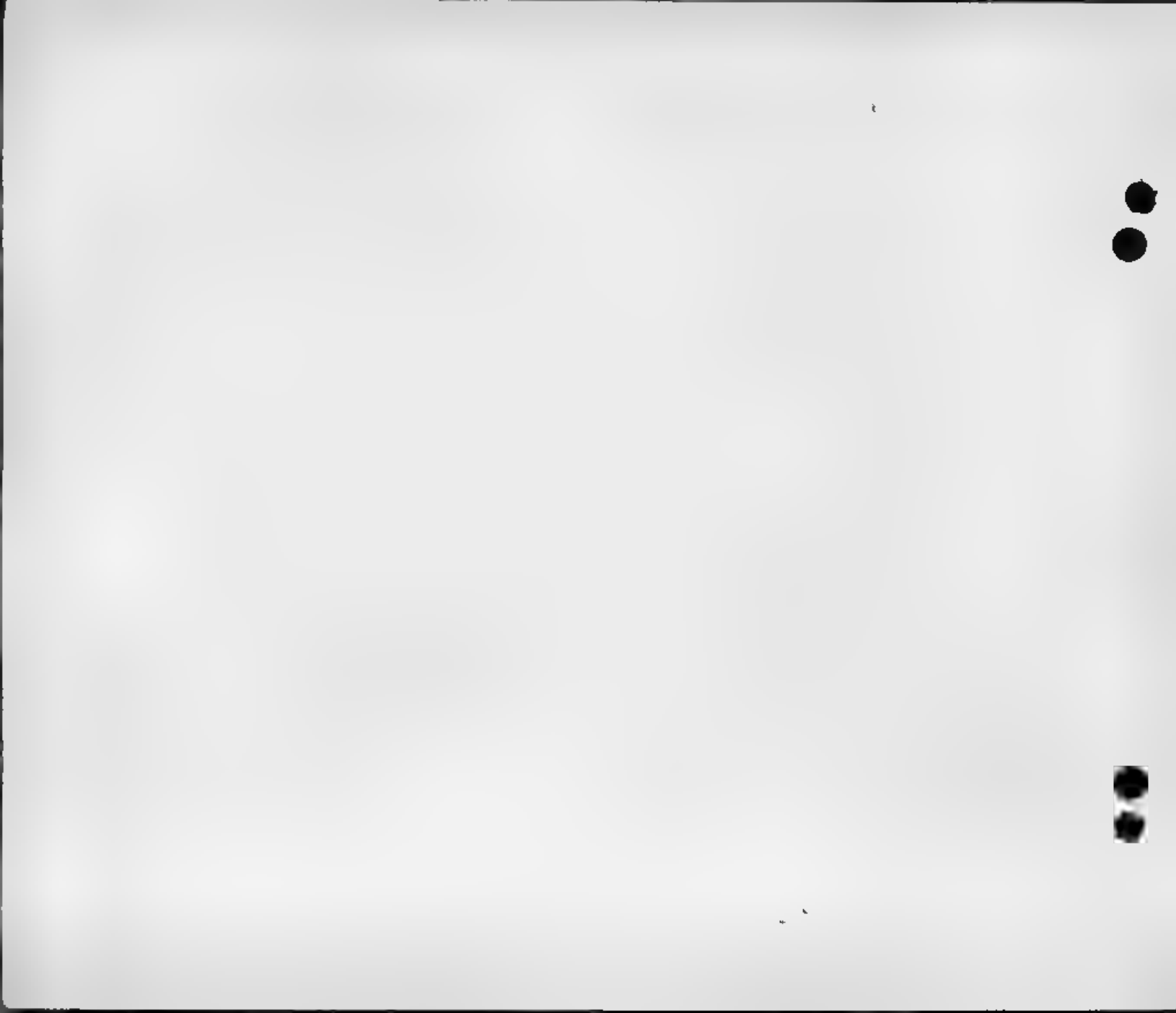
42

1. PLACE OF DEATH COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1111 N. Wolfe St</u>		STREET ADDRESS (If rural, give location) <u>409 N. Wolfe St</u>	
3. NAME OF DECEASED (Type or Print) <u>George DAVIS</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>26</u> - Year <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify, <u>WIDOWED</u>)	8. DATE OF BIRTH <u>9-19-90</u>
9a. USUAL OCCUPATION (If vendor of work done during most of working life, even if retired) <u>LABORER</u>	9b. KIND OF BUSINESS OR INDUSTRY <u>Southon R.R.</u>	10. BIRTHPLACE (State or foreign country) <u>VA.</u>	11. CITIZEN OF WHAT COUNTRY? <u>USA</u>
12. FATHER'S NAME <u>John DAVIS</u>		13. MOTHER'S MAIDEN NAME <u>FANNIE MEDLEY</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) <u>WW II</u>		15. SOCIAL SECURITY NO. <u>5-31-55</u>	
16. INFORMANT AND ADDRESS <u>FANNIE JOHNSON 409 N. Wolfe St</u>		17. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
350 Immediate cause (a) <u>Respiratory Paralysis</u>			
Antecedent cause(s) (b) <u>Pericarditis</u>			
Disease or condition, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pharyngitis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
18a. DATE OF OPERATION		18b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT, SUICIDE, HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg. etc.) (CITY OR TOWN) (COUNTY, STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 29, 1954</u> to <u>Nov 1, 1955</u> , that I last saw the deceased alive on <u>Nov 1, 1955</u> , and that death occurred at <u>2:15 p.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>Nov 1, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE REC'D BY LOCAL REG. <u>5-31-55</u>		LOCATION (City, town, or county) (State) <u>NATIONAL 5501 Frederick Ave</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Joseph B. Lockhart 1508 N. Central</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04355

Item 9. Film 13-1-55 et

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>100</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgemoor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgemoor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2714 Edgemoor</u>		STREET ADDRESS (If rural, give location) <u>2714 Edgemoor</u>	
3. NAME OF DECEASED (First) <u>Josa</u> (Middle) <u>Ann</u> (Last) <u>Davis</u>		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>October 14, 1878</u> 1/77 yrs.	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE State or foreign country <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm. J. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Untersinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2714 8-1-55</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Clara Goodie</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>broncho pneumonia</u>		<u>10 days</u>	
Antecedent cause(s) (b) <u>arterio sclerosis, H. pylori</u>		<u>u.t.</u>	
(c) <u>stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED (While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 29, 1955</u> , to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 10th, 1955</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. J. E. Howard</u>		DATE SIGNED <u>May 10, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>		DATE THEREOF <u>5-12-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Laplace</u>		LOCATION (City, town, or county) (State) <u>La</u>	
DATE RECEIVED BY LOCAL REG. <u>5-12-55</u>		REGISTRAR'S SIGNATURE <u>Rayner Sanders</u>	
FUNERAL DIRECTOR <u>Rayner Sanders</u>		ADDRESS <u>217 E. Preston St</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04356

4382

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>	
TOWN <u>Notch Cliff</u>		TOWN <u>Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd</u>		STREET ADDRESS <u>Glenarm Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Praxedes Tick</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 28, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>90</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter Tick</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Harnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md.</u>			

13. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary artery disease</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>My hypertensive cardio renal vascular condition</u> (c)			<u>2 yrs.</u> <u>15 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		22. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from April, 1952, to May 25, 1955, that I last saw the deceased alive on May 24, 1955, and that death occurred at 6:00 P. m., from the causes and on the date stated above.

SIGNATURE:

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>5-28-55</u>	<u>VILLA MARIA CEM., NOTCH CLIFF NR TOWSON, MD.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>5-28-55</u>	<u>Charles A. Gailer</u>	<u>901 S. CONKLING ST.</u>	<u>BALTO., MD.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4383

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04357

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTO. CO.</u> MARYLAND	STATE <u>MD</u> COUNTY <u>BALTO</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>EATONSVILLE, 28</u>	
CITY <u>EATONSVILLE</u> LENGTH OF STAY <u>LIFE</u>	OR TOWN <u>EATONSVILLE, 28</u>	STREET ADDRESS <u>114 SMITHWOOD AVE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 SMITHWOOD</u>	DATE (Month) (Day) (Year) OF DEATH <u>5/14/55</u>		
3 NAME OF DECEASED (First) (Middle) (Last)	4 DATE OF BIRTH (Month) (Day) (Year)		
<u>ERNEST DIEHLMANN</u>	<u>NOV. 7, 1882</u>		
5 SEX <u>M</u> 6 COLOR OR RACE <u>W</u> 7 SINGLE <u>WIDOWED</u> 8 MARRIED <u>DIVORCED</u> 9 AGE last birthday <u>72</u> yrs	10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office</u>		
10B KIND OF BUSINESS OR INDUSTRY <u>BALTO. TRANSIT</u>	11 BIRTHPLACE (State or foreign country) <u>MD</u>		
13 FATHER'S NAME <u>FREDERICK DIEHLMANN</u>	14 MOTHER'S MAIDEN NAME <u>ELIZABETH BECKMAN</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16 SOCIAL SECURITY NO. <u>MD</u>		
17 INFORMANT'S NAME <u>Mrs. Cornelia Diehlmann</u>	18 MEDICAL CERTIFICATION		
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Left heart, blood, and vessels</u>		<u>Long</u>	
ANTECEDENT CAUSE (B) <u>None</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>None</u>			
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B PLACE (Home, farm, factory or INJURY street, office bldg., etc)	21C WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-6</u> , 19 <u>53</u> , to <u>5-14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-14</u> , 19 <u>55</u> , and that death occurred at <u>1:50</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>5-17-55</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>5/18/55</u>	NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>	LOCATION (City, town, or county) (State) <u>BALTO. CO.</u>
DATE REC'D BY LOCAL REGISTRAR <u>5/18/55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24 FUNERAL DIRECTOR <u>Mac Webb & Son</u>	ADDRESS

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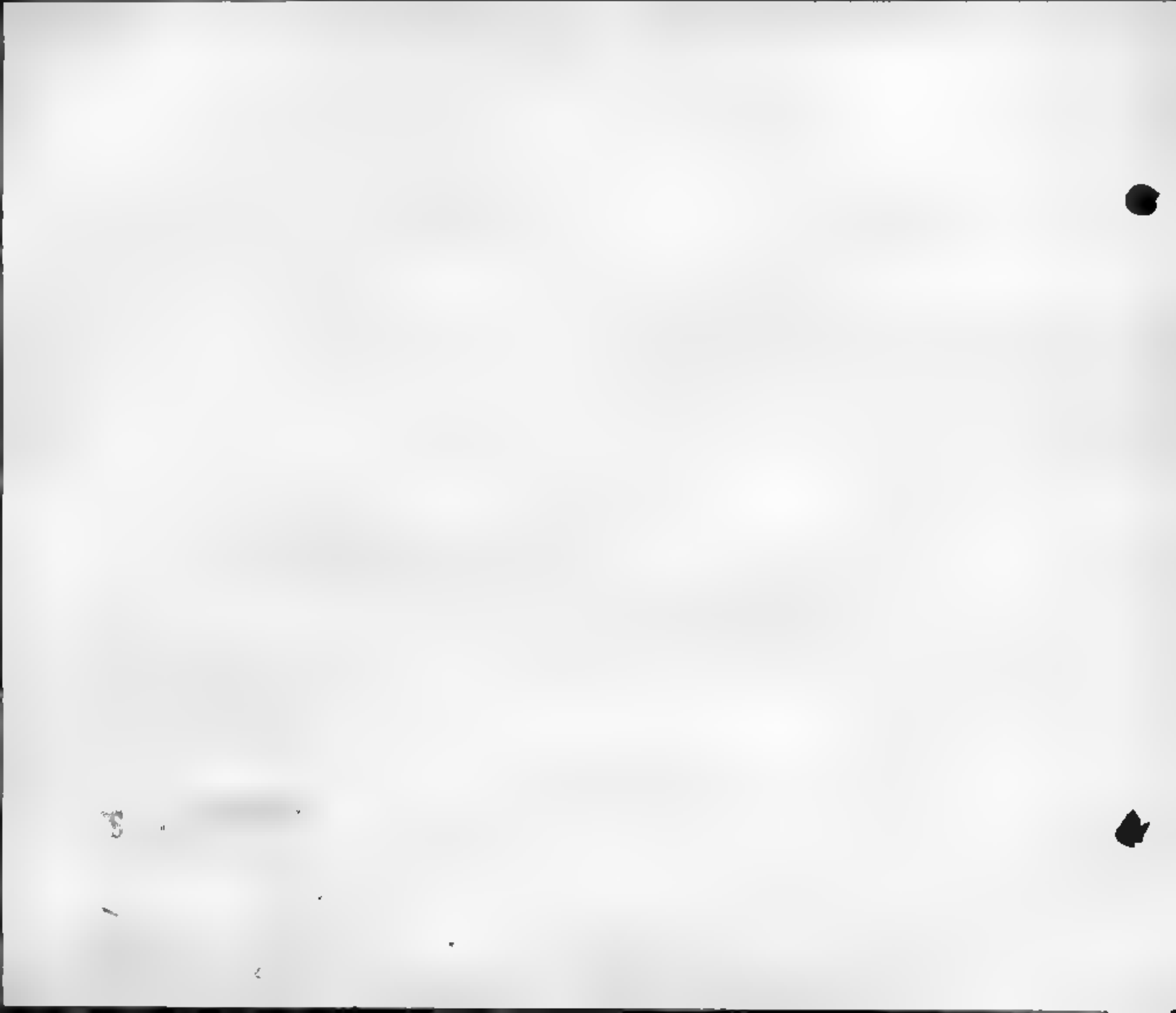
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Calto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY <u>if outside corporate limits, write RURAL</u>	LENGTH OF STAY <u>(in this place)</u>	CITY <u>if outside corporate limits, write RURAL and give nearest town</u>	OR
TOWN <u>Randallstown</u>		TOWN <u>Randallstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Liberty Rd.</u>		STREET ADDRESS <u>Liberty Rd., Ex 222</u>	
3 NAME OF DECEASED (Type or Print) <u>CAROLINE DORFNER</u>	4 DATE Month (Day) (Year) <u>May 24 1955</u>	5 AGE at birth <u>81</u> <u>yr</u> <u>mo</u> <u>da</u> <u>hr</u> <u>min</u>	
6 SEX <u>female</u>	7 COLOR OR RACE <u>white</u>	8 DATE OF BIRTH <u>Dec. 9, 1873</u>	9 BIRTHPLACE State or foreign country <u>Balto. Co., Md.</u>
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	10B KIND OF BUSINESS OR INDUSTRY <u>--</u>	11 CITIZENSHIP OF WHAT COUNTRY <u>U.S.A.</u>	
12 FATHER'S NAME <u>Andrew P. Myers</u>	13 MOTHER'S MAIDEN NAME <u>Annie C. Sauder</u>	14 INFORMANT & ADDRESS <u>Mr. Harvey M. Quimby - Randallstown, Md. Ex 222</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>no</u>	16 SOCIAL SECURITY NO. <u>---</u>	17 MEDICAL CERTIFICATION	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
IMMEDIATE CAUSE <u>420.1</u>		(A) <u>Coronary thrombosis</u>	
ANTECEDENT CAUSE (B) <u>Cardiovascular disease</u>		(B) <u>Cardiovascular disease</u>	
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(C) <u>---</u>	
18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>---</u>			
19A DATE OF OPERATION <u>---</u>	19B MAJOR FINDINGS OF OPERATION <u>---</u>	20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiners)	21B PLACE (Home, farm, factory, street, office bldg, etc.)	21C WHERE D.D. (City or town) (County) (State)	21D TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY <u>M</u>
21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21F HOW DID INJURY OCCUR? <u>---</u>		
22 I hereby certify that I attended the deceased from <u>5/24/55</u> to <u>5/24/55</u> , that I last saw the deceased alive on <u>5/24/55</u> , and that death occurred at <u>M. from the causes and on the date stated above</u>			
SIGNATURE <u>Dr. E. Martin</u>		DATE SIGNED <u>5/24/55</u>	
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/26/55</u>		FUNDAL DIRECTOR <u>William J. Tiekens</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist No.

043587

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME, OF DECEASED)	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	LENGTH OF STAY (in this place) <u>47415</u>	CITY (If outside corporate limits, write RURAL, and give nearest town, OR TOWN <u>Phoenix</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Phoenix Rd</u>		STREET ADDRESS (If rural, give location) <u>Phoenix Rd</u>	
3 NAME OF DECEASED (Type or Print) <u>Benjamin John DORN</u>		4 DATE OF DEATH (Month) (Day) (Year) <u>May 17 1955</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE MARRIED <u>MARRIED</u>	8 DATE OF BIRTH <u>14 December 1884</u>
9 AGE last birthday <u>70</u> yrs		10 AGE last birthday IF UNDER 1 YEAR IF UNDER 20 HRS. Months Days Hours Min.	
10A USUAL OCCUPATION Give kind of work done during most of working life even if retired <u>mechanic</u>	10B KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	11 BIRTHPLACE (State or foreign country) <u>Phoenix, Pott Co Ind</u>	12 CITIZEN OF WHAT COUNTRY <u>USA</u>
13 FATHER'S NAME <u>John Dorn</u>		14 MOTHER'S MAIDEN NAME <u>Annie Schmitt</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>217-12-9383</u>	
17 INFORMANT'S ADDRESS <u>Son - Gilbert Dorn Timonium Md</u>			
18 MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1-7X IMMEDIATE CAUSE		(A) DUE TO <u>Carcinomatosis</u>	
ANTECEDENT CAUSE (S)		(B) DUE TO <u>Carcinoma head of pancreas</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>Feb. 1955</u>		19B MAJOR FINDINGS OF OPERATION <u>Carcinoma Head of Pancreas.</u>	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	
21C WHERE DID (City or town) (County) (State)		21D TIME (Month) (Day) (Year) (Hour)	
21E INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/12/1955</u> to <u>5/12/1955</u> that I last saw the deceased alive on <u>5/12/1955</u> and that death occurred at <u>9:50 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>M. X. Quinn</u>		DATE SIGNED <u>5/17/55</u>	
23 BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-20-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Christened Grave</u>		LOCATION (City, town, or county) <u>Phoenix, Baltimore Md</u>	
DATE REC'D BY LOCAL REG STRAR <u>20 May 55</u>		REGISTRAR'S SIGNATURE <u>Anne Unmick MacRae</u>	
FUNDAL DIRECTOR <u>Brother Francis Xavier, S.M.</u>		ADDRESS <u>Brother Francis Xavier, S.M.</u>	

ARGIN RESERVED FOR B BING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU U. S.

APR 28 1917

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04359

4385

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

37

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL, and give nearest town) Timonium		CITY (If outside corporate limits, write RURAL and give nearest town) Timonium	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1838 Locust Ridge Road		STREET ADDRESS 1838 Locust Ridge Road	
3. NAME OF DECEASED (First, (Middle) (Last) CHARLES CAYWOOD DUVAL		4. DATE OF DEATH Month May Day 17 , Year 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Specify single	8. DATE OF BIRTH Feb. 26, 1955
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE last birthday If under 1 year: Months 2 Days 22 If under 1 year: Months 2 Days 22
10. FATHER'S NAME Robert C. Duvall, Jr.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		13. SOCIAL SECURITY No. ---	
14. MOTHER'S MAIDEN NAME Marie Gorecki		15. INFORMANT AND ADDRESS Dr. Robert C. Duvall, 1838 Locust Ridge Rd.	

16. MEDICAL CERTIFICATION

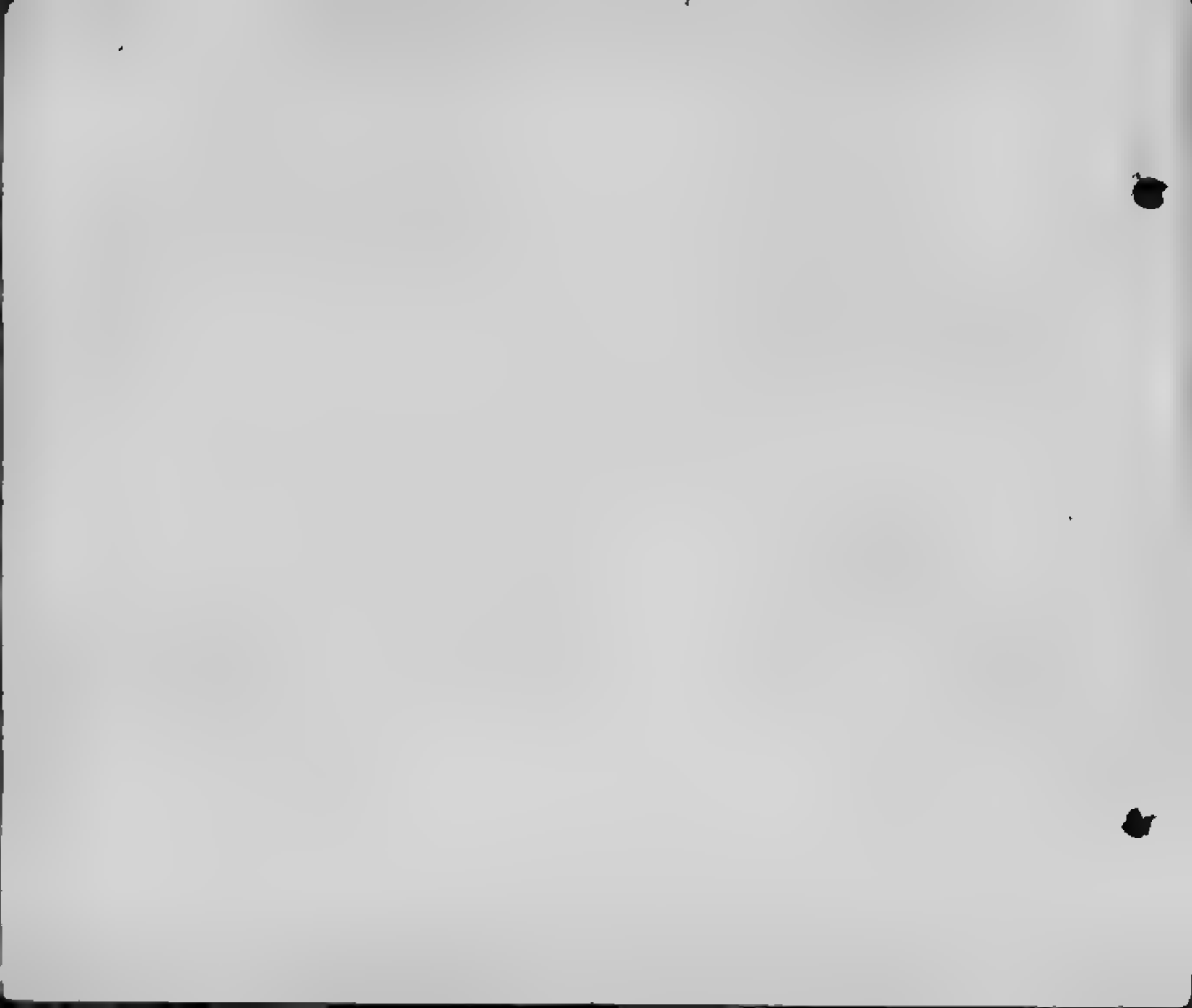
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH Sudden 24 hrs
<p>470X Immediate cause (a) Operation of Heart Arteries</p> <p>Antecedent cause (b) "Cold"</p> <p>Disease or condition, if any, giving rise to the above cause, stating the underlying cause as:</p>		
2. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death)		

10a. DATE OF OPERATION	10b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<p>11. PERSON, ALSO WAS PLACE (Home, farm, factory, street, office bldg., etc.) PRIMARY OR CONTRIBUTING DEATH OF INJURY Home</p> <p>TIME Month May Day 17 Year 1955 AM 5:00</p> <p>INJURY OCCURRED While at work <input type="checkbox"/> While on work <input type="checkbox"/></p> <p>HOW DID INJURY OCCUR?</p>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. SIGNATURE (Degree or title) Charles F. Duvall, M.D.		ADDRESS 2501 York Rd.		DATE SIGNED 5/17/55
22. BY LOCAL REGISTRAR'S SIGNATURE 6-18-55		23. BY VERIFIED DIRECTOR Sam Bork, Inc.		24. ADDRESS 1217 St. Paul Street

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information on carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information is carefully supplied. Physicians: please write the names of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

4386

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04360 31

CERTIFICATE OF DEATH

Reg. Dist. No.

31
32

1 NAME OF DECEASED (Type or Print) <i>Harry Hayden Edwards</i>		2 DATE OF DEATH <i>May 15, 1955</i>	
3 PLACE OF DEATH A <i>Baltimore City, Maryland</i>		4 USUAL RESIDENCE (Where deceased lived at institution—reside now before admission) A STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>	
5 FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Road</i>		C CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Randallstown</i>	
6 Length of stay in Baltimore <i>Life</i>		D STREET ADDRESS (If rural, give location) <i>Church Rd. Randallstown</i>	
7 SEX <i>Male</i>	8 COLOR OR RACE <i>White</i>	9 MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	10 DATE OF BIRTH <i>Oct 19, 1865</i>
11 AGE (in years last birthday) <i>89</i>	12 AGE (in months last birthday) <i>8</i>	13 AGE (in days last birthday) <i>8</i>	14 AGE (in hours last birthday) <i>8</i>
15 USUAL OCCUPATION (Give kind of work during most of work life, even if retired) <i>Retired Carpenter</i>		16 KIND OF BUSINESS OR INDUSTRY <i>Carpentry</i>	
17 BIRTHPLACE (State or foreign country) <i>Maryland-Baltimore</i>		18 C. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
19 FATHER'S NAME <i>Thomas Henry Edwards</i>		20 MOTHER'S MAIDEN NAME <i>Matilda Robinson</i>	
21 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		22 SOCIAL SECURITY NO. <i>NO</i>	
23 INFORMANT <i>Harry H. Edwards</i>		24 ADDRESS <i>Church Rd.</i>	
25 CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardio Vascular Disease</i> DUE TO II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST <i>Cheyne Stokes Respiration</i> DUE TO III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR COND. ON CAUSING I. <i>None</i>			
26 IF OPERATION WAS RELATED TO CAUSE OF DEATH ENTER IN 27 DATE OF OPERATION (Day, Year, Hour) <i>May 12, 1955</i>		28 CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>	
29 INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30 HOW DID INJURY OCCUR? <i>None</i>	
31 I certify that (I) (this hospital) attended the deceased from <i>May 12, 1955</i> to <i>May 14, 1955</i> that (I) (we) last saw the deceased alive on <i>May 14, 1955</i> and that death occurred at <i>4:00 a.m.</i> from the causes and on the date stated above.			
32 SIGNATURE OF ATTENDING PHYSICIAN <i>Wm. E. Martin</i>		33 ADDRESS <i>Randallstown Md</i>	
34 DATE RECEIVED BY LOCAL REG. STRAR <i>5/16/55</i>		35 REGISTRAR'S SIGNATURE <i>Wm. E. Martin</i>	
36 FUNERAL DIRECTOR <i>Frank D. Newell</i>		37 ADDRESS <i>None</i>	
38 BURIAL CREMATION REMOVAL (Specify) <i>BURIAL</i>		39 DATE <i>MAY 17, 1955</i>	
40 NAME OF CEMETERY OR CREMATORY <i>MT. OLIVE</i>		41 LOCATION (City, town, or county) (State) <i>RANDALLSTOWN MD</i>	

34 1000

70
1000

4344

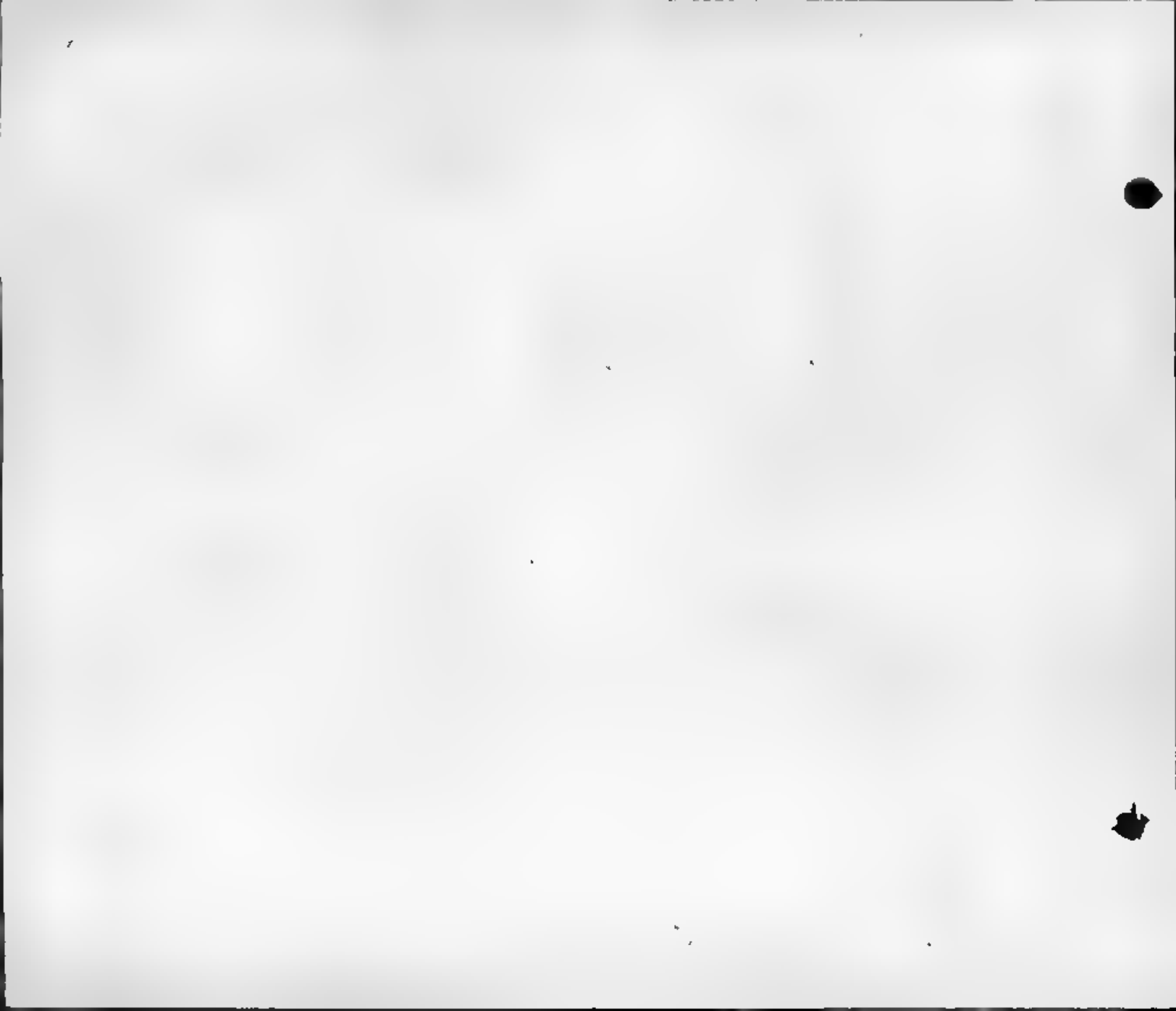
CERTIFICATE OF DEATH

Reg Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto</u> MARYLAND	CITY (If outside corporate limits write RURAL and give nearest town) <u>Lansdowne</u>	STATE <u>Md.</u> COUNTY <u>Balto</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>
OR TOWN <u>Lansdowne</u>	LENGTH OF STAY (In this place) <u>1</u>	OR TOWN <u>Lansdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>28 2nd Ave</u>		STREET ADDRESS (If rural give location) <u>28 2nd Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Elizabeth Ruth Elliott</u>		DATE OF DEATH <u>May 2 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE MARRIED <u>Married</u>	8. DATE OF BIRTH <u>12/3/1896</u>
	9. AGE last birthday <u>58</u> yrs.	10. WIDOWED DIVORCED (Specify)	11. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. FATHER'S NAME <u>Edwin H. Ely</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. MOTHER'S MAIDEN NAME <u>Blanche Webb</u>		14. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>George Elliott</u>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
		I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
IMMEDIATE CAUSE <u>151X</u>		(A) <u>Carcinoma of the stomach</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B)	
		DUE TO	
		(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month, (Day) Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/7</u> , 1955, to <u>5/1</u> , 1955, that I last saw the deceased alive on <u>5/1</u> , 1955, and that death occurred at <u>11 A. M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Howard J. Lirickas</u>		DATE SIGNED <u>5/3/55</u>	
ADDRESS <u>M D 2436 Washington Rd</u>			
23. BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-4-55</u>		REGISTRAR'S SIGNATURE <u>William Cook</u>	
FUNERAL DIRECTOR'S ADDRESS <u>1517 St Paul St</u>			

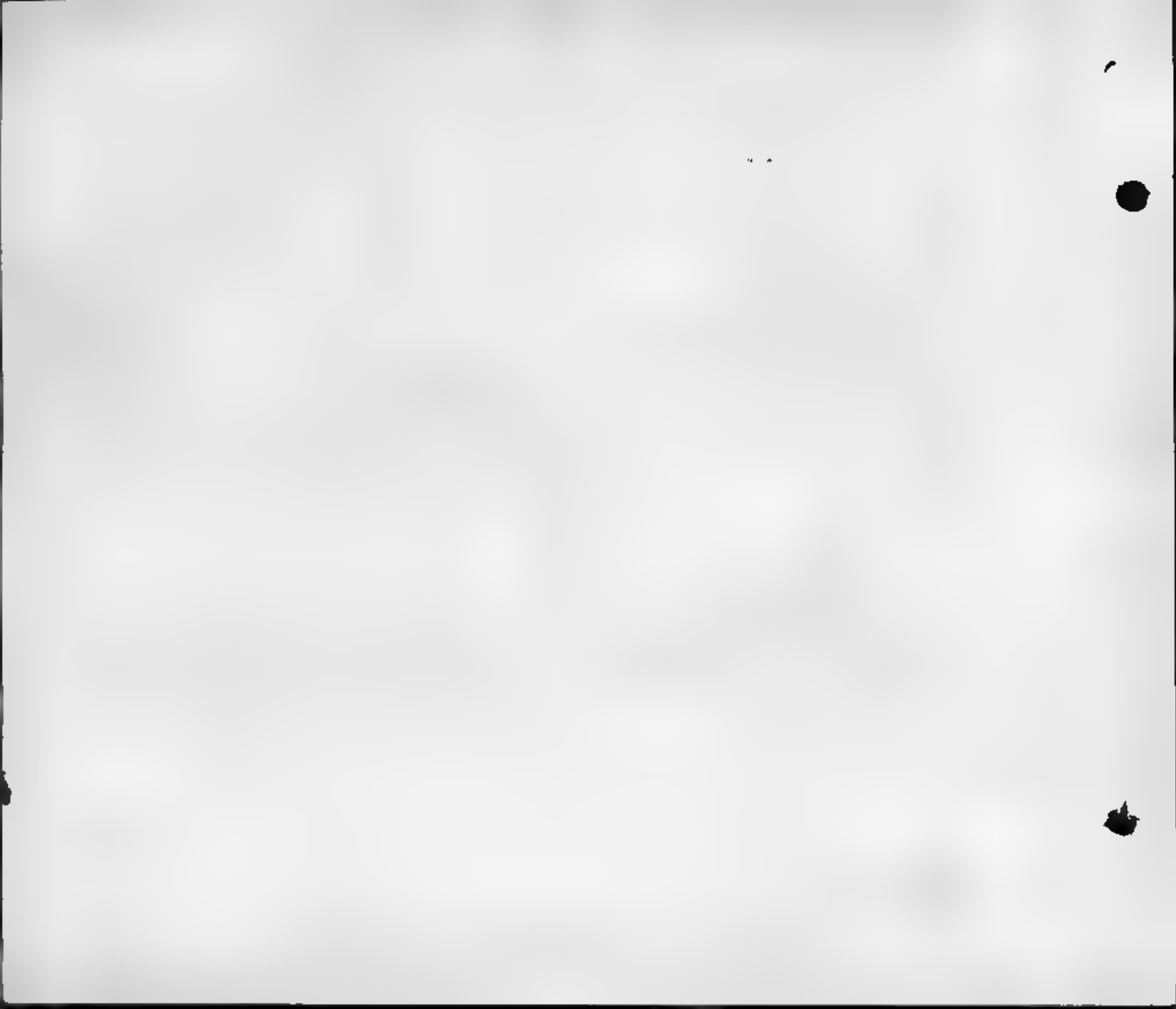
MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4387 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04362			
CERTIFICATE OF DEATH			
1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN FORT HOWARD</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits write RURAL and give nearest town) OR <u>TOWN BALTIMORE</u> STREET ADDRESS (If rural give location) <u>5245 4th STREET</u>	
3 NAME OF (Type or Print) <u>CHARLES L ENNIS</u>		4 DATE OF DEATH <u>MAY 20 1955</u>	
5 SEX <u>MALE</u>		6 AGE last birthday <u>68</u> yrs	
7 COLOR OR RACE <u>WHITE</u>		8 DATE OF BIRTH <u>7/28/86</u>	
9 SINGLE MARRIED <u>WIDOWED</u>		10 AGE last birthday <u>68</u> yrs	
11 US AL OCCUPATION Give kind of work done during most of work ng life even if retired <u>STEAM FITTER</u>		12 KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
13 FATHER'S NAME <u>JOSEPH ENNIS</u>		14 BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>YES</u> (If Yes, give war or dates of service) <u>WW-I</u>		16 MOTHER'S MAIDEN NAME <u>BARBARA ONGLER</u>	
17 SOCIAL SECURITY NO. <u>UNKNOWN</u>		18 INFORMANT'S ADDRESS <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>	
19 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CARCINOMA OF MAXILLARY SINUS WITH EXTENSION TO RIGHT NECK</u> ANTECEDENT CAUSE (B) <u>160X</u> DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>UNKNOWN</u>		<u>2 Years</u>	
20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>CIRRHOSIS OF LIVER</u>		<u>Unknown</u>	
21A DATE OF OPERATION <u>2</u>		21B MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home farm factory street, office bldg, etc) INJURY OCCUR? <u>VAH, FORT HOWARD, MD.</u>	
21C TIME (Month) (Day) (Year) (Hour) OF INJURY		21D INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21E HOW DID INJURY OCCUR?		21F WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22 I hereby certify that I attended the deceased from <u>May 14, 1955</u> , to <u>May 20, 1955</u> , and that death occurred at <u>8:04 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>WILLIAM E. VANDEGRIFT, M.D.</u>		DATE SIGNED <u>5/22/55</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEMETERY</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
REGISTRAR'S SIGNATURE <u>W. E. VanDegrift</u>		24 FUNERAL DIRECTOR <u>WILLIAM COOK-BLIGHT INC</u>	
		ADDRESS <u>6009 HARFORD RD BALTO. MD.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

4388

04363

Item 14, 1-1-1952 6-2-52 et

1. PLACE OF DEATH COUNTY Balto		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) Fullerton		CITY (If outside corporate limits, write RURAL and give nearest town) Fullerton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 31 Henry Ave.		STREET ADDRESS (If rural, give location) 31 Henry Ave	
3. NAME OF DECEASED (Type or Print) Elmer		4. DATE OF DEATH (Month) May (Day) 23 (Year) 1955	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. A. A. OF BIRTH April 25-1905	
9. AGE last birthday 50 yrs.		10. AGF last birthday 50 yrs.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy Maker		12. KIND OF BUSINESS OR INDUSTRY Own Business	
13. FATHER'S NAME Harry Euler		14. MOTHER'S MAIDEN NAME Dona Milleris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs Elmer Euler, 31 Henry Ave	
17. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Coronary Occlusion - Cardiac Arrest.			
Antecedent cause(s) (b) Hypertensive Cardiovascular Disease.			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Nephritis (Nephrosclerosis)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT (Specify) HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. I hereby certify that I attended the deceased from 3-1 , 19 54 , to 5-23 , 19 55 , that I last saw the deceased alive on 5-23 , 19 55 , and that death occurred at 8 p.m. from the causes and on the date stated above.			
SIGNATURE John C. Hyle M.D.		DATE SIGNED 5-24-55	
22. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 26-1955	
NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Balto Md.	
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE May 25-55		23. FUNERAL DIRECTOR Lansham Funeral Home 7401 Belair Rd	

FOR THE U. S.

4389

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04364

CERTIFICATE OF DEATH

Reg Dist No. 38

Item 4, Film 6181 5-17-55 et

1. PLACE OF DEATH

BALTO.

COUNTY Towson 4,

CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) (in this space)

50 TOWN

MARYLAND

4 years

HOSPITAL OR
INSTITUTION OR
STREET ADDRESSThe Sheppard & Enoch Pratt Hospital
Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Washington, 12, D.C. COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

STREET ADDRESS

(If rural give location)

3. NAME OF
DECEASED:

First,

(Middle

(Last)

Type or Print

Edith

Bentley

Farguhar

5. SEX:

Female

6. COLOR OR
RACE:

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): widow

8. DATE OF BIRTH:

10/30/66

4. DATE
OF
DEATH

Month

(Day

Year)

5

12

13, 1955

9. AGE last birthday IF UNDER 1 YEAR, IF UNDER 24 HRS.
88 yrs. Month Days Hours Min10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired housewife10b. KIND OF BUSINESS OR
INDUSTRY.11. BIRTHPLACE (State or foreign country)
Sandy Spring, Maryland12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Edward P. Thomas

14. MOTHER'S MAIDEN NAME.
Mary Bentley15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service) no

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) RUPTURED ARTERIOSCLEROTIC ANEURYSM
DUE TO ABDOMINAL AORTA

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.(b) GENERALIZED ARTERIOSCLEROSIS
DUE TO

(c)

Interval Between
Onset And Death

10 MIN

5 YEARS

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY mINJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 29, 1951, to May 13, 1955, that I last saw the deceased
alive on May 12, 1955, and that death occurred at 1:45 AM from the causes and on the date stated above
SIGNED: J. M. D. THE SHEPPARD & ENOCH PRATT HOSPITAL, Towson, Md. 5/13/55
DATE SIGNED: May 13, 195523. BURIAL, REMOTION,
REMOVAL (Specify)
DATE REC'D BY LOCAL
REGISTRAR

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county

(State)

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 13, 1955

Mabel C. Gray

Warner E. Humphrey, Inc.

Sandy Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write to the causes of death clearly and legibly.

U. S. V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04365

4390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY **BALTIMORE** MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) **CATONSVILLE** LENGTH OF STAY (in this place)

HOSPITAL OR NURSING HOME, CATONSVILLE
STREET ADDRESS **RIDGEWAY MANOR-NURSING HOME, CATONSVILLE**

3. NAME OF DECEASED

(First) **MOLLYE** (Middle) **V.** (Last) **FELDT**

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE MARRIED

MARRIED

8. DATE OF BIRTH

AUG. 18, 1886

4. DATE (Month Day Year)

MAY 21, 1955

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min

68

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

O.H.

11. BIRTHPLACE (State or foreign country)

BALTO. MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

CHARLES W. FURY

14. WAS DECEASED EVER IN U.S. ARMED FORCES?

Yes, no, or unk. (If Yes, give war or dates of service)

14. SOCIAL SECURITY NO.

14. MOTHER'S MAIDEN NAME

ANNA A. LASTNER

17. INFORMANT'S ADDRESS

MR. OTTO F. FELDT, 5019 FREDERICK

18. MEDICAL CERTIFICATION

18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) DUE TO

(B) DUE TO

(C)

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A. DATE OF OPERATION

12-9-54

19B. MAJOR FINDINGS OF OPERATION

Pseudomucinous adenocarcinoma, rt. ovary with metastasis

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

2. TIME (Month) (Day) (Year) (Hour) OF INJURY

M

21E. INJURY OCCURRED

While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec. 15, 1953**, to **May 21, 1955** that I last saw the deceased alive on **May 21, 1955**, and that death occurred at **5:20 PM** from the causes and on the date stated above

SIGNATURE

John F. Slawer

M.D.

401 - Brandon Road

DATE SIGNED

5/23/55

23. BURIAL CREMATION REMOVAL (Specify)

BURIAL

DATE THEREOF

MAY 24/55

NAME OF CEMETERY OR CREMATORY

BALTO. NATIONAL

LOCATION (City town or county)

BALTO. MD.

DATE REC'D BY LOCAL REGISTRAR

3-23-55

REGISTRAR'S SIGNATURE

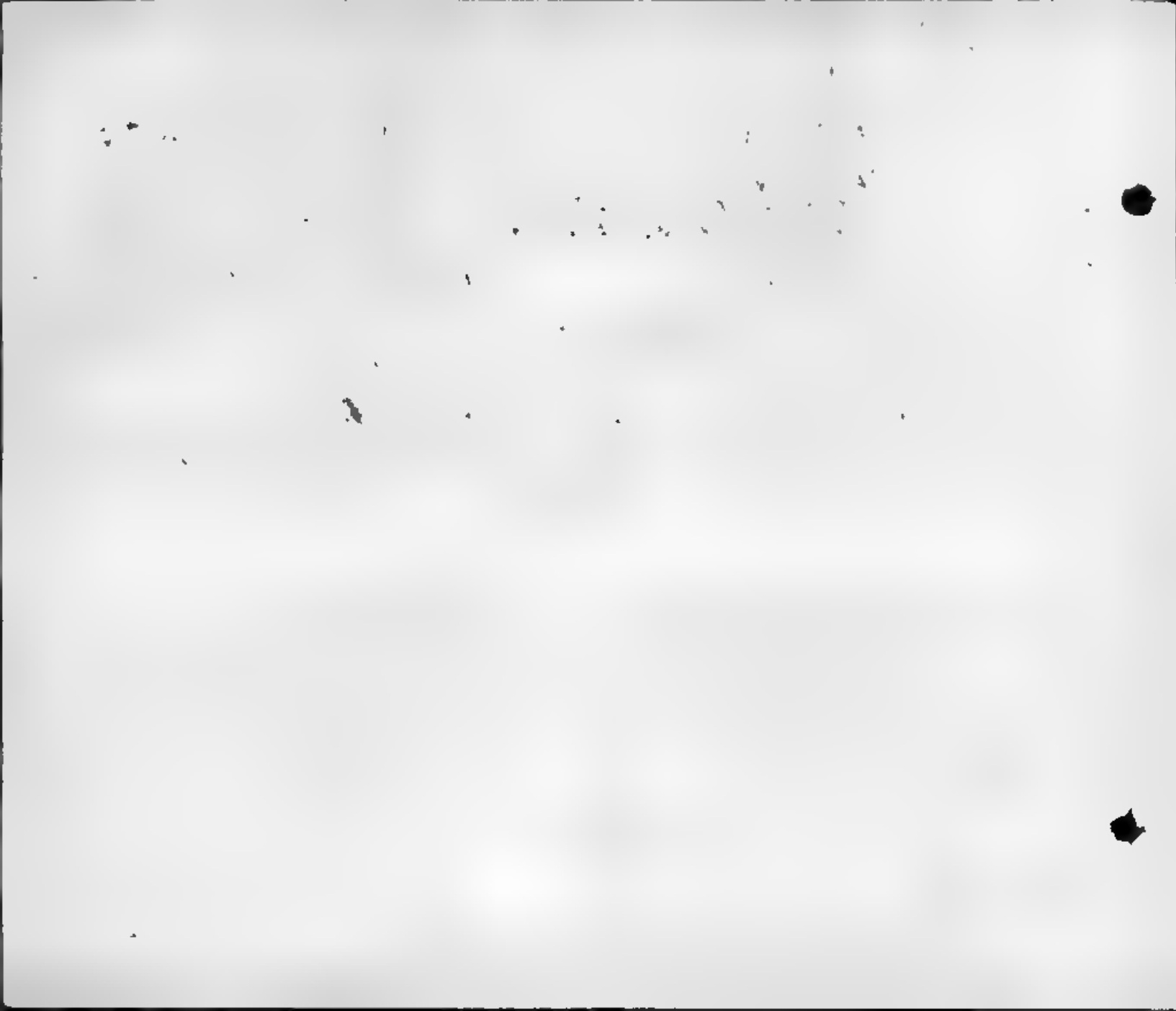
John F. Slawer

24. FUNERAL DIRECTOR

Harry H. Wight

ADDRESS

4101 EDMONDSON AVE



4391

CERTIFICATE OF DEATH

Reg Dist No. 30

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY
CITY If outside corporate limits, write RURAL and give nearest town	LENGTH OF STAY (in this place)	CITY If outside corporate limits, write RURAL and give nearest town	
TOWN Catonsville	42yr 11mo 3days	TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural give location)	
3 NAME OF DECEASED (First) (Middle) (Last)	4 DATE (Month) (Day) (Year)		
Catherine Finzel	May 3, 1955		
5 SEX 6 COLOR OR RACE 7 SINGLE MARRIED 8 DATE OF BIRTH 9 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS	10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B KIND OF BUSINESS OR INDUSTRY	
Female 100 White Single 1870	Domestic		
11 FATHER'S NAME	12 CITIZEN OF WHAT COUNTRY?	13 MOTHER'S MAIDEN NAME	
Unknown	USA	Unknown	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give way or dates of service)	15 SOCIAL SECURITY NO	16 INFORMANT & ADDRESS	
No	Unknown	Neeress Spring Grove State Hospital	
17 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18 MEDICAL CERTIFICATION	
266X IMMEDIATE CAUSE		(A) Arteriosclerotic cardiovascular disease Years	
ANTECEDENT CAUSE (S)		(B) Generalized severe arteriosclerosis Years	
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(C) Diabetes Mellitus Years	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		Lebility and -nility Years	
19A DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A ACCIDENT WAS UNDEVELOPING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER	21B PLACE (Home farm factory etc) OF INJURY street office bldg etc	21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> as work <input type="checkbox"/>	21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-26-1938 to 5-4-1955 that I last saw the deceased alive on 5-4-1955, and that death occurred at 1:00 PM from the causes and on the date stated above			
SIGNATURE S Wachter		DATE SIGNED 5-6-55	
23 BURIAL CREMATION REMOVAL (SPECIFY)		DATE OF DEATH 5-4-55	
DATE REC'D BY LOCAL REGISTRAR 5/6/55		REGISTRAR'S SIGNATURE U.E. Harry	
		24 FUNERAL DIRECTOR J-J Fagan & Son 1318 Light	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



NB: PLEASE INFORM LL OF THE ~~INDIVIDUAL~~
NAME, OF APPLICANT REQUESTING COPY
OF THIS DEATH CERT.

(LL- CALL CATHOLIC CHARITIES * Sa.7-7240,
Miss Varnhorn)



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4392

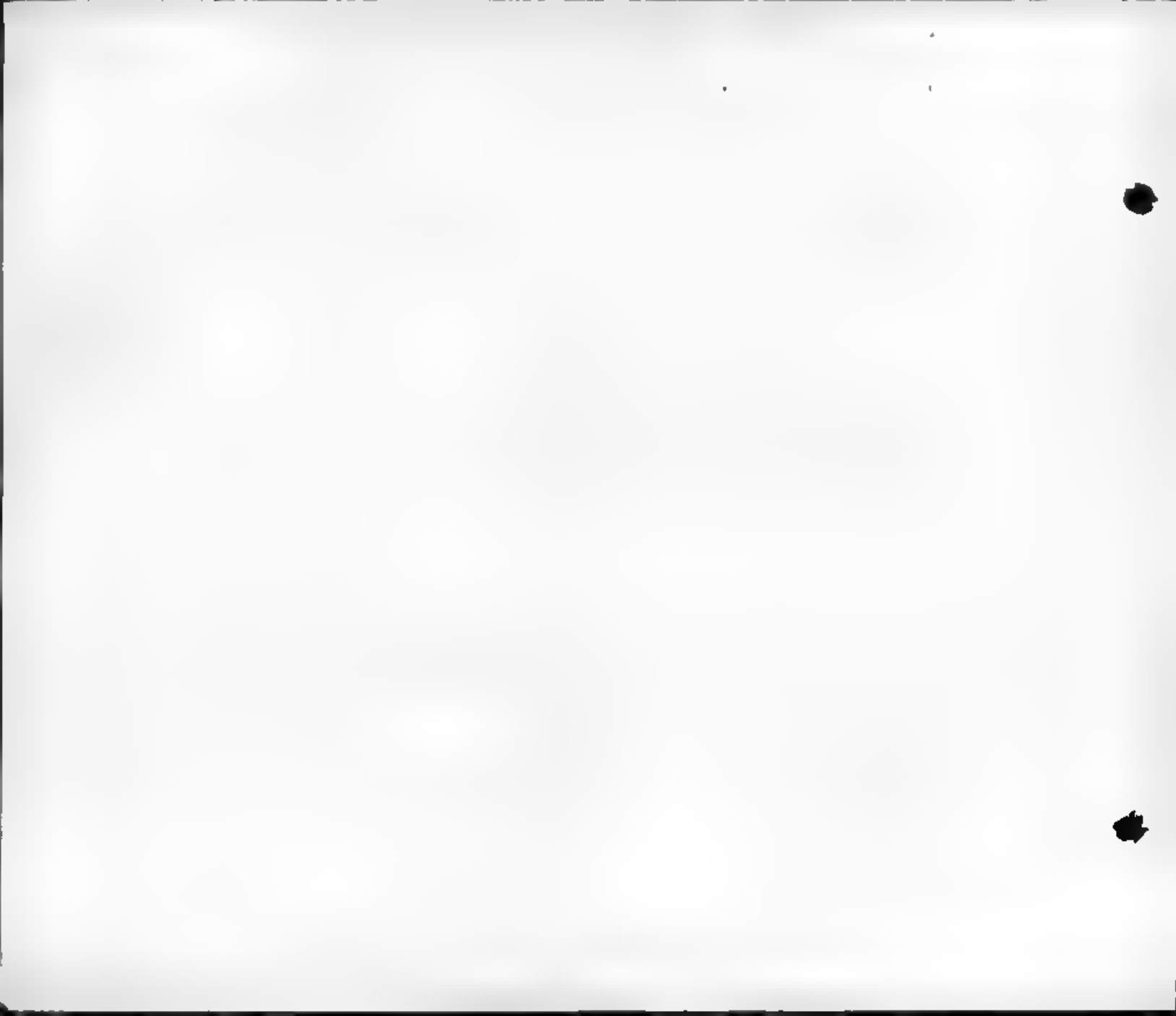
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04367

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND CITY <u>If outside corporate limits, write RURAL</u> LENGTH OF STAY <u>112 days</u> OR <u>and give nearest town</u> (in this case) TOWN <u>Catonsville</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY <u>If outside corporate limits, write RURAL and give nearest town</u> OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS <u>8807 N. Baker Avenue</u> (If rural give location)	
3 NAME OF DECEASED (Type or Print)		4 DATE OF DEATH	
First <u>Eugene</u> (Middle) <u>.</u> Last <u>Ford</u> SEX <u>Male</u> RACE <u>White</u>		DATE (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1955</u>	
5 SEX <u>Male</u> 6 CC OR OR 7 SINGLE MARRIED 8 DATE OF BIRTH <u>12-31-1886</u>		9 AGE last birthday (If under 1 year If under 24 hrs Months Days Hours Min. <u>68</u> yrs)	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Stationary Engineer</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10B KIND OF BUSINESS OR INDUSTRY <u>RET</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William Ford</u>		14 MOTHER'S MAIDEN NAME <u>Georgiana LeveTT</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give way or dates of service) <u>Unknown</u>		16 SOCIAL SECURITY NO. <u>216-10-6379</u>	
17 INFORMANT'S ADDRESS <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u> ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u> Yrs. <u>5 days</u> DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>4-22-55</u>		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDEVELOPING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21B PLACE (Home, farm, factory, street, office bldg., etc.)	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D TIME (Month Day) (Hour) (Minute) OF INJURY <u>M</u>		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-22-55</u> to <u>5-4-55</u> , that I last saw the deceased alive on <u>5-1-55</u> , and that death occurred at <u>12:45 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		DATE SIGNED <u>5-1-55</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		LOCATION (City or town) (County) (State) <u>Bal To Co - Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-5-55</u>		REGISTRAR'S SIGNATURE <u>a w h</u>	
24 FUNERAL DIRECTOR <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Bayford</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

4393

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>Md.</i>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pikesville</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pikesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>107 Reisterstown Rd.</i>		STREET ADDRESS (If rural give location) <i>512 Reisterstown Rd.</i>	
3. NAME OF DECEASED: (First) <i>CHARLES</i> (Middle) <i>L</i> (Last) <i>FREENY</i>		4. DATE OF DEATH: (Month) <i>5</i> (Day) <i>29</i> (Year) <i>1953</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Oct 2, 1879</i>
9. AGE last birthday: <i>73</i> yrs.		10. AGE last birthday, If UNDER 1 YEAR: (Months) (Days) (Hours) (Min.)	
11a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>OPERATOR</i>		11b. KIND OF BUSINESS OR INDUSTRY: <i>TAVERN</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <i>?</i>	
14. MOTHER'S MAIDEN NAME: <i>?</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <i>-</i>		17. INFORMANT & ADDRESS: <i>Mary K. Freeny 512 Reisterstown Rd.</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) DUE TO <i>Coronary Thrombosis</i>			<i>18 hrs.</i>
Antecedent causes (b) DUE TO <i>Art. Sclerosis</i>			<i>10 yrs.</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan. 1945</i> , to <i>May 29th, 1953</i> , that I last saw the deceased alive on <i>May 29, 1953</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE OF REGISTRAR <i>James A. Miller</i>		DATE SIGNED <i>5/31/53</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <i>6/1/55</i>	NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>	LOCATION (City, town, or county) (State) <i>Pikesville Md.</i>
DATE REC'D BY LOCAL REGISTRAR <i>6-1-55</i>	REGISTRAR'S SIGNATURE <i>A. W. Hedrick</i>	FUNERAL DIRECTOR'S SIGNATURE <i>Paul E. Hedrick</i>	ADDRESS <i>3615-17 Chestnut Ave</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

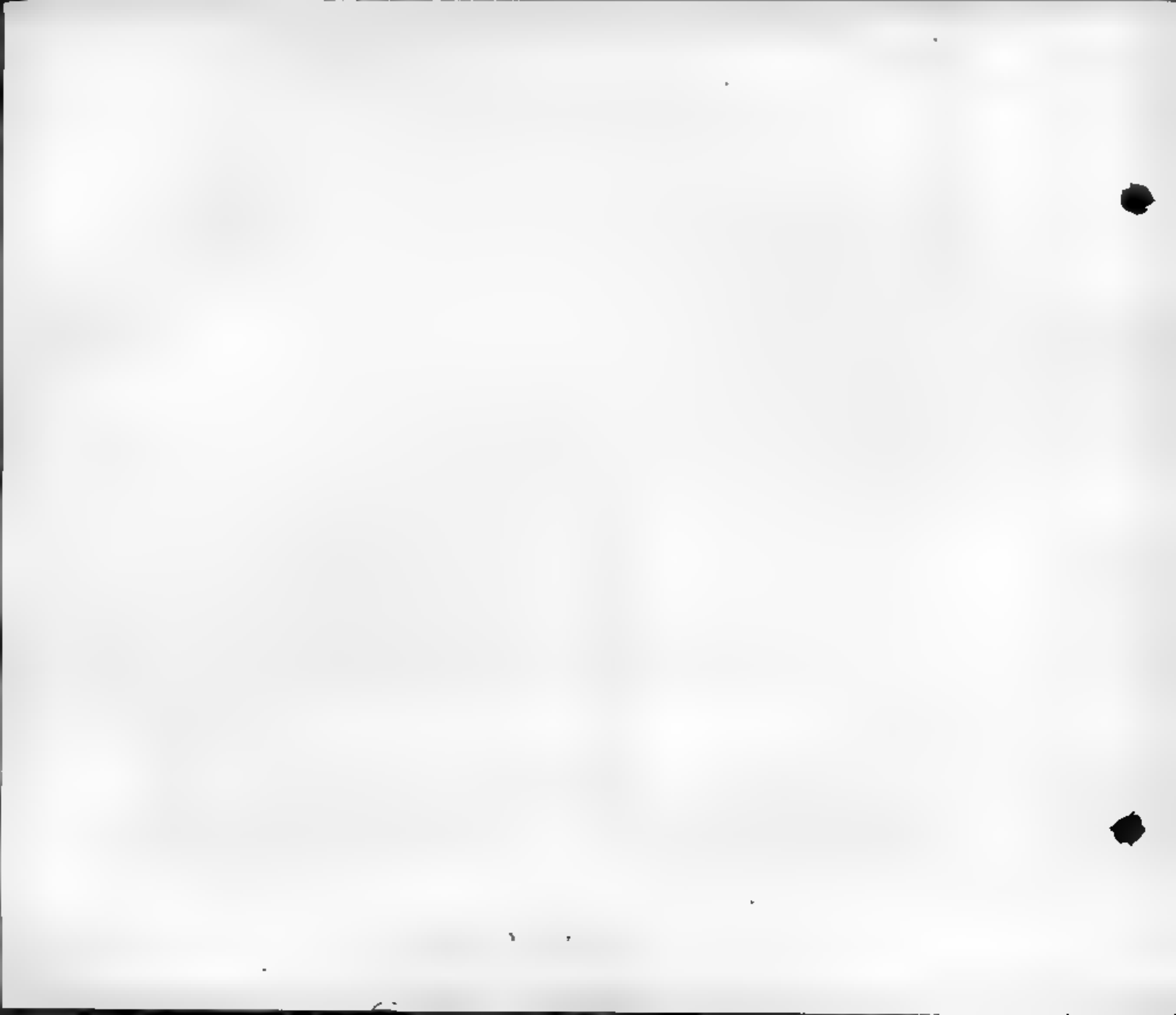


MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY BALTIMORE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FORT HOWARD, 4 Hours 40M. HOSPITAL OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STATE MARYLAND COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE STREET ADDRESS (If rural give location) 1037 HOLLINS STREET	
3 NAME OF DECEASED (Type or Print)		4 DATE (Month) (Day) (Year)	
First Middle (Last) SOL (NMI) FRIEDMAN MAY 4 1955		DEATH MAY 4 1955	
5 SEX 6 CO OR OR 7 SINGLE MARRIED		8 DATE OF BIRTH 9 AGE (and birthdate)	
MALE WHITE W. DOWED MARRIED SPECIFY MARRIED 9-22-05 49 Yrs		10 UNDER 1 YEAR IF OVER 1 YEAR Months Days Hours Min	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10B KIND OF BUSINESS OR INDUSTRY	
TAXI DRIVER			
11 FATHER'S NAME		12 CITIZEN OF WHAT COUNTRY?	
ISAAC FRIEDMAN		U. S. A.	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
ISAAC FRIEDMAN		ROSE SASS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give year or dates of service		16 SOCIAL SECURITY NO	
YES, WW-II		211-03-0115	
17 INFORMANT & ADDRESS		18 MEDICAL CERTIFICATION	
CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) SCLERODERMA ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)	
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
L		PNEUMONIA, RIGHT LOWER LOBE	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
		6 MONTHS	
21A ACCIDENT WAS UNDEFINING OR CONTRIBUTING CAUSE OF DEATH? IF EITHER NOTIFY MEDICAL EXAMINER		21B PLACE (Home, farm, factory, street, office bldg., etc.) INJURY OCCURRED	
		21C WHERE DIED (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED (While at work or Not while at work)	
VA		9:30 P.M. 1:40 A.M.	
22 I hereby certify that I attended the deceased from MAY 3, 1955, to MAY 4, 1955, and that death occurred at 1:40 AM from the causes and on the date stated above.		23 BURIAL (SPECIFY) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City or town or county) State	
SIGNATURE Francis G. Dickey, M.D., Chief, Medical Service VAH, Fort Howard, Maryland DATE REC'D BY LOCAL REGISTRAR 5-5-55		ADDRESS DATE SIGNED BALTIMORE NATIONAL BALTIMORE, MARYLAND REGISTRAR'S SIGNATURE A. W. Hedberg FUNERAL DIRECTOR Sol Levinson & Bros., 1126 W. North Ave. Baltimore, Maryland Sol Levinson & Bros. Inc.	

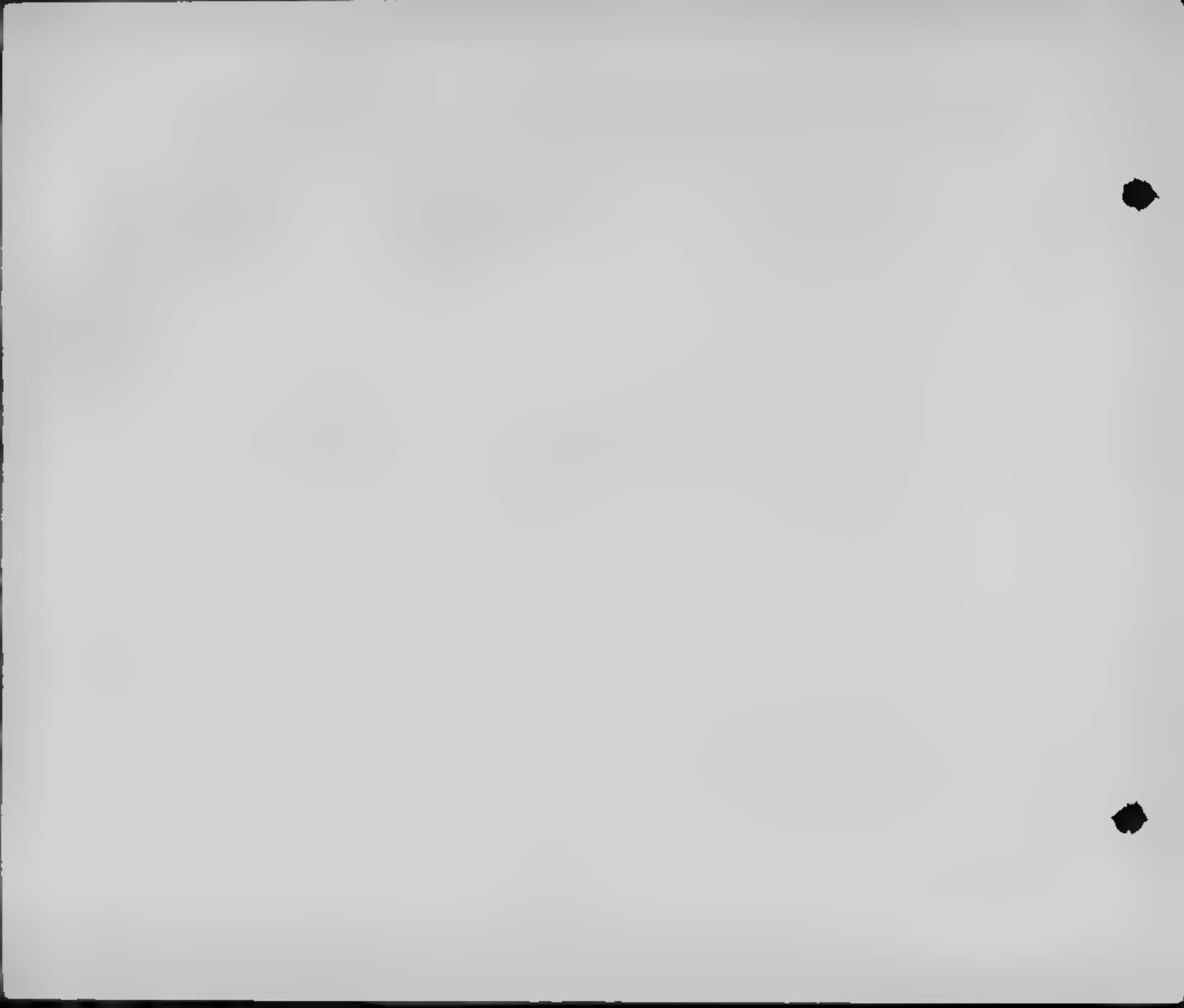


4395

Reg. Dist. No.

It was 7-11-68 7-11-68 at

PLACE OF DEATH COUNTY		BALTIMORE		MARYLAND		UNITAL RESIDENCE (HOME) OF DECEASED STATE		Maryland		COUNTY		Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		PARKVILLE		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		PARKVILLE		STREET ADDRESS		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		7909 WESTMORLAND AVE		7909 W. Moreland Ave		7909 W. Moreland Ave		7909 W. Moreland Ave		7909 W. Moreland Ave		7909 W. Moreland Ave	
3. NAME OF DECEASED (Type or Print)		OTTO F		(Middle)		F		(Last)		F		4. DATE OF DEATH (Month Day, Year)	
5. SEX		MALE		6. COLOR OR RACE		WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, Specify		8. DATE OF BIRTH		FEB 4, 1886	
9. AGE (last birthday)		69 yrs		10. AGE (last birthday)		69 yrs		11. BIRTHPLACE (State or foreign country)		POLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or UNKNOWN)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION		Immediate cause		Antecedent cause a) Disease or condition, if any, giving rise to the above cause stating the underlying cause last		b) Disease or condition, if any, giving rise to the above cause stating the underlying cause last		Interval Between Onset and Death		Sudden		5 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. SIGNATURE OF INFORMANT		22. DATE SIGNED		23. PLACE OF BURIAL OR CREMATION	
24. TIME (Month) (Day) (Year)		25. PLACE OF INJURY		26. HOW DID INJURY OCCUR?		27. SIGNATURE OF INFORMANT		28. DATE SIGNED		29. PLACE OF BURIAL OR CREMATION		30. LOCAL HEALTH OFFICER'S SIGNATURE	
31. TIME (Month) (Day) (Year)		32. PLACE OF INJURY		33. HOW DID INJURY OCCUR?		34. SIGNATURE OF INFORMANT		35. DATE SIGNED		36. PLACE OF BURIAL OR CREMATION		37. LOCAL HEALTH OFFICER'S SIGNATURE	
38. TIME (Month) (Day) (Year)		39. PLACE OF INJURY		40. HOW DID INJURY OCCUR?		41. SIGNATURE OF INFORMANT		42. DATE SIGNED		43. PLACE OF BURIAL OR CREMATION		44. LOCAL HEALTH OFFICER'S SIGNATURE	
45. TIME (Month) (Day) (Year)		46. PLACE OF INJURY		47. HOW DID INJURY OCCUR?		48. SIGNATURE OF INFORMANT		49. DATE SIGNED		50. PLACE OF BURIAL OR CREMATION		51. LOCAL HEALTH OFFICER'S SIGNATURE	
52. TIME (Month) (Day) (Year)		53. PLACE OF INJURY		54. HOW DID INJURY OCCUR?		55. SIGNATURE OF INFORMANT		56. DATE SIGNED		57. PLACE OF BURIAL OR CREMATION		58. LOCAL HEALTH OFFICER'S SIGNATURE	
59. TIME (Month) (Day) (Year)		60. PLACE OF INJURY		61. HOW DID INJURY OCCUR?		62. SIGNATURE OF INFORMANT		63. DATE SIGNED		64. PLACE OF BURIAL OR CREMATION		65. LOCAL HEALTH OFFICER'S SIGNATURE	
66. TIME (Month) (Day) (Year)		67. PLACE OF INJURY		68. HOW DID INJURY OCCUR?		69. SIGNATURE OF INFORMANT		70. DATE SIGNED		71. PLACE OF BURIAL OR CREMATION		72. LOCAL HEALTH OFFICER'S SIGNATURE	
73. TIME (Month) (Day) (Year)		74. PLACE OF INJURY		75. HOW DID INJURY OCCUR?		76. SIGNATURE OF INFORMANT		77. DATE SIGNED		78. PLACE OF BURIAL OR CREMATION		79. LOCAL HEALTH OFFICER'S SIGNATURE	
80. TIME (Month) (Day) (Year)		81. PLACE OF INJURY		82. HOW DID INJURY OCCUR?		83. SIGNATURE OF INFORMANT		84. DATE SIGNED		85. PLACE OF BURIAL OR CREMATION		86. LOCAL HEALTH OFFICER'S SIGNATURE	
87. TIME (Month) (Day) (Year)		88. PLACE OF INJURY		89. HOW DID INJURY OCCUR?		90. SIGNATURE OF INFORMANT		91. DATE SIGNED		92. PLACE OF BURIAL OR CREMATION		93. LOCAL HEALTH OFFICER'S SIGNATURE	
94. TIME (Month) (Day) (Year)		95. PLACE OF INJURY		96. HOW DID INJURY OCCUR?		97. SIGNATURE OF INFORMANT		98. DATE SIGNED		99. PLACE OF BURIAL OR CREMATION		100. LOCAL HEALTH OFFICER'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4396

CERTIFICATE OF DEATH

04371

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3007 LAVENDER AVE</u>		STREET ADDRESS (If rural, give location) <u>3007 LAVENDER AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDGAR</u>	(Middle) <u>S</u>	(Last) <u>FRY</u>
6. SEX <u>M</u>	7. COLOR OR RACE <u>W</u>	8. SINGLE, MARRIED, WIDOWED <u>DIVORCED</u> (Specify)	9. DATE OF BIRTH <u>MAY 13, 1882</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	12. AGE last birthday <u>73</u> yrs.	13. DATE OF DEATH <u>MAY 17, 1955</u>
14. FATHER'S NAME <u>JAMES C FRY</u>	15. MOTHER'S MAIDEN NAME <u>MARIE BRYON</u>	16. DATE OF BIRTH <u>MAY 13, 1882</u>	17. AGE last birthday <u>73</u> yrs.
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	19. SOCIAL SECURITY NO. <u>NONE</u>	20. INFORMANT <u>MRS RUTH RICH</u>	21. ADDRESS <u>3007 LAVENDER AVE</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary thrombosis</u>		<u>6 week</u>
Antecedent cause(s) (b) <u>"</u>		<u>4 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 17, 1955, to May 17, 1955, that I last saw the deceased alive on May 17, 1955, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

SIGNATURE Harold H. Burns ADDRESS MD 8106 Harford Rd DATE SIGNED MAY 18, 1955

23. BUREAU OF CREMATION (If cremated) DATE THEREOF MAY 20, 1955 NAME OF CEMETERY OR CREMATORY St. John's Lutheran Church LOCATION (City, town, or county) BALTIMORE (State) MD

DATE RECD BY LOCAL REG. 5/19/55 REGISTRAR'S SIGNATURE R. M. B. B. B. 24. FUNERAL DIRECTOR CROSS & EVANS & SON ADDRESS 8502 Harford Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of information is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

1911

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04372

CERTIFICATE OF DEATH

Reg. Dist. No. 5

The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. US. AL RESIDENCE (HOME, OF DECEASED) STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Ave</u>		STREET ADDRESS (If rural, give location) <u>Paradise Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Joseph J. Fuller</u>		4. DATE OF DEATH (Last, Middle, First) <u>5-17-1955</u> (Year, Month, Day) <u>1955</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>11-17-1873</u> 9. AGE (last birthday, If under 24 hrs. Months, Days, Hours, Min.) <u>81</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>M's Georgana Watkins</u>	
17. INFORMANT AND ADDRESS <u>Paradise Ave.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardio Vascular Disease @
atherosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden
6 months

II OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month, (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/12, 1955, to 5/14/55, 1955, that I last saw the deceased

alive on 5/10, 1955, and that death occurred at 5:00 P m., from the causes and on the date stated above.

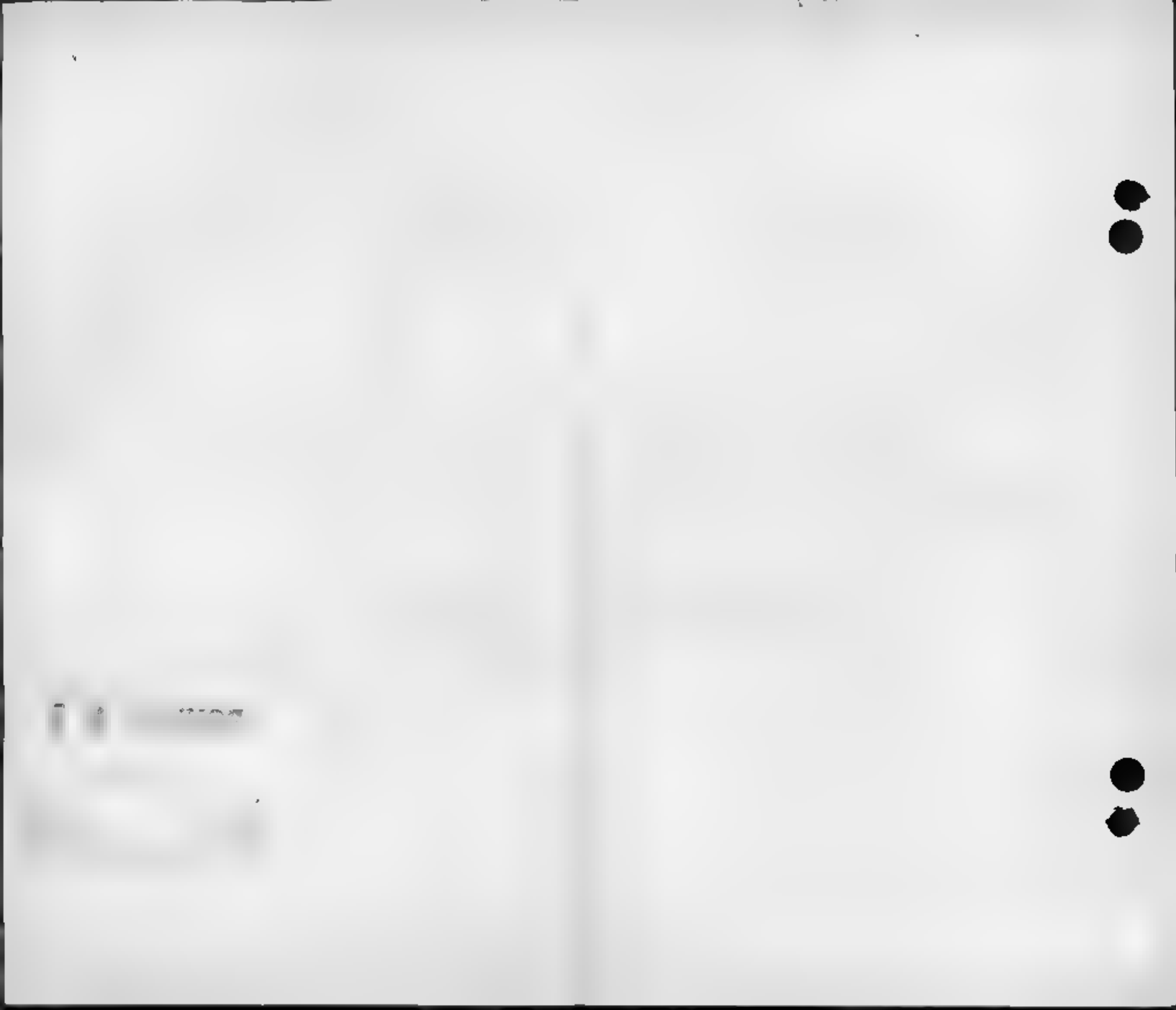
SIGNATURE: Elmer W. Johnson (Degree or title) ADDRESS: 2632 Frederick Ave Baltimore 28 Md DATE SIGNED: 5/17/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-17-55</u>	<u>Mt. Auburn Cem</u>	<u>Baltimore</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR ADDRESS		
<u>5/18/55</u>	<u>[Signature]</u>	<u>Mrs. Frances A. Heasley</u> <u>Baltimore</u>		

IN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04373

4399

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND CITY <u>Catonsville</u> LENGTH OF STAY <u>3 yrs 27 days</u> OR <u>3 yrs 27 days</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Spring Grove State Hosp</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY If outside corporate limits, write RURAL and give nearest town) <u>3101-4</u> OR TOWN <u>Baltimore</u> STREET ADDRESS <u>1012 Roland Heights Ave.</u>	
3 NAME OF DECEASED (Type or Print) <u>Catherine Fredricka Funk</u>		4 DATE OF DEATH <u>May 1, 1955</u>	
5 SEX <u>Female</u> 6 CO OR OR 7 SINGLE MARRIED <u>Widowed</u> 8 DATE OF BIRTH <u>Jan. 26, 1972</u>		9 AGE (last birthday) <u>83</u> yrs Months Days Hours Min.	
10A USUAL OCCUPATION (give kind of work done or principal of working life even if retired) <u>None</u>		10B KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 FATHER'S NAME <u>August Gernert</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 MOTHER'S MAIDEN NAME <u>Margaret Hertzberger</u>		14 INFORMANT & ADDRESS <u>Hospital Records</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>-</u>	
17 MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>			
ANTECEDENT CAUSE (B) <u>Terminal cardio-respiratory failure</u>			
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Generalized arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Malnutrition and multiple decubitus ulcers</u>			
19A DATE OF OPERATION <u>-</u>		19B MAJOR FINDINGS OF OPERATION <u>-</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. PLACE (Home, farm, factory, etc.) OF INJURY <u>-</u>	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, notify medical examiner) <u>-</u>		21B WHERE DID INJURY OCCUR? <u>-</u>	
21C TIME (Month (Day) (Year) (Hour) OF INJURY <u>-</u>		21D INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21E HOW DID INJURY OCCUR? <u>-</u>		21F HOW DID INJURY OCCUR? <u>-</u>	
22. I hereby certify that I attended the deceased from <u>April 4, 1952</u> , to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>April 30, 1955</u> , and that death occurred at <u>4:52 PM</u> from the causes and on the date stated above			
SIGNATURE <u>John P. Rusley MD.</u>		DATE SIGNED <u>5/1/55</u>	
23. BURIAL, CREMATATION, OR REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/1/55</u>	
NAME OF CEMETERY OR CEMATORY <u>Not Olmit</u>		LOCATION (City or town or county) <u>Federick Ave.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/3/55</u>		REGISTRAR'S SIGNATURE <u>Paul E. Lehmann</u>	
FUNERAL DIRECTOR <u>Paul E. Lehmann</u>		ADDRESS <u>365-17 Clinton Ave.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04374

Reg. Dist. No. 42

4345

1 PLACE OF DEATH.				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> OR TOWN <u>Arbutus</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4204 Leeds Avenue -29</u>				STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> OR TOWN <u>Arbutus</u> STREET ADDRESS (If rural give location) <u>4204 Leeds Avenue -29</u>			
3 NAME OF DECEASED:		First (Type or Print) <u>Ella</u>		(Middle) <u>Gateman</u>		(Last) <u>Gateman</u>	
4 DATE OF DEATH:		(Month) <u>May</u>		(Day) <u>29</u>		(Year) <u>1955</u>	
5 SEX: <u>Female</u>		6 COLOR OR RACE: <u>White</u>		7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8 DATE OF BIRTH: <u>April 1, 1872</u>	
9 AGE last birthday: <u>83</u> yrs.		10 MONTHS: <u>00</u>		11 DAYS: <u>00</u>		12 HOURS: <u>00</u>	
13. FATHER'S NAME: <u>Napoleon Peddicord</u>				14. MOTHER'S MAIDEN NAME: <u>Isabel Stansbury</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY No.: <u>---</u>			
17. INFORMANT & ADDRESS: <u>Mrs. G. Russell Thomas- 4204 Leeds Avenue, 29</u>							
13. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Coronary Thrombosis</u>							
Antecedent causes (b) <u>Chronic - 12-10-54. Insane</u>							
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
12. DATE OF OPERATION: 13. MAJOR FINDINGS OF OPERATION							
14. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)							
22. I hereby certify that I attended the deceased from <u>May 26, 1955</u> to <u>May 29, 1955</u> , that I last saw the deceased alive on <u>May 24, 1955</u> , and that death occurred at <u>8:45 PM</u> from the causes and on the date stated above							
SIGNATURE <u>Harry Glassman M.D.</u> ADDRESS <u>2007 Maple Ave. Baltimore, Md.</u> DATE SIGNED <u>May 29, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>June 1, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u> LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>							
DATE REC'D BY LOCAL REGISTRAR <u>5-31-55</u> REGISTRAR'S SIGNATURE <u>R. W. Peddicord</u> 24. FUNERAL DIRECTOR <u>G. Russell Thomas, 4204 Leeds Avenue Balto. 29, Md.</u> ADDRESS <u>---</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

04375

4399

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

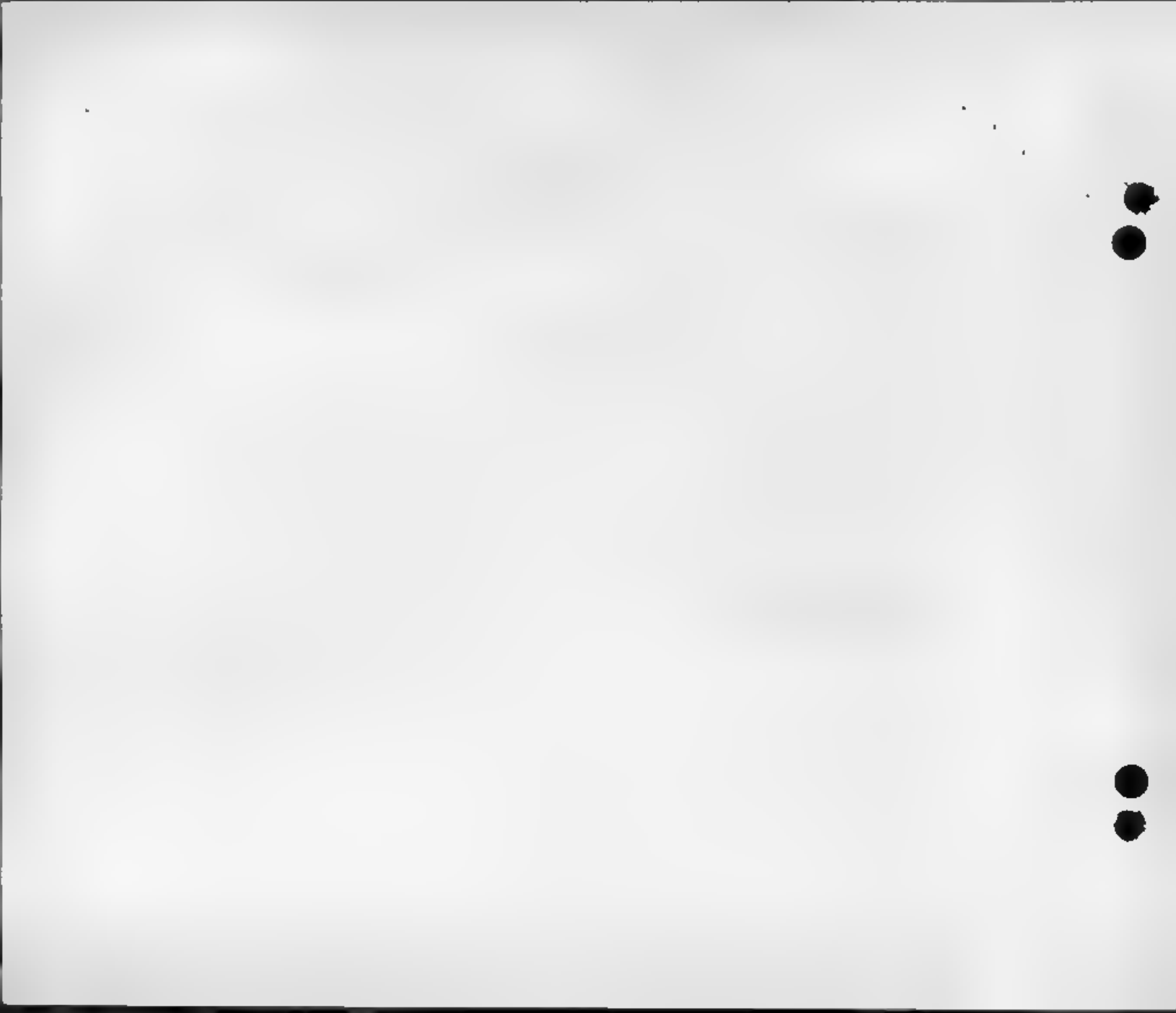
Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines N. Home</u>		STREET ADDRESS (If rural, give location) <u>5011 Tupip Ave. - Relay</u>	
3. NAME OF DECEASED (Type or Print) <u>Susan</u>		4. DATE OF DEATH (Month) <u>Heres</u> (Day) <u>10</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Oct 1-1890</u>
9. AGE last birthday <u>64</u> yrs.		10. UNDER 1 year Months <u>5</u> Days <u>10</u>	11. UNDER 24 hrs Hours <u>19</u> Mins. <u>55</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Quateria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Quateria</u>	
13. FATHER'S NAME <u>Christopher Heres</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Temple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Dorothy Dorch 4113 Hague Ave. Brooklyn</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Hypertensive A.S.C.V.D.</u>			
Antecedent cause(s) (b) <u>Diabetes Mellitus</u>			
(c) <u>giving rise to the above cause stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>		INJURY OCCURRED <u>White at Work</u> <input type="checkbox"/> <u>Not White At work</u> <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/2</u> , 19 <u>54</u> , to <u>5/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/14</u> , 19 <u>55</u> and that death occurred at <u>6:45</u> p.m. from the causes and on the date stated above.			
SIGNATURE <u>John C. Healy M.D.</u>		DATE SIGNED <u>5/15/55</u>	
23. BURIAL, CREMATION OR DISPOSAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>5/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Ferncliff</u>		LOCATION (City, town, or county) (State) <u>New York City</u>	
24. REG. BY LOCAL REG. <u>5-16-55</u>		25. FUNERAL DIRECTOR <u>Wm Cook Inc 1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15



CERTIFICATE OF DEATH

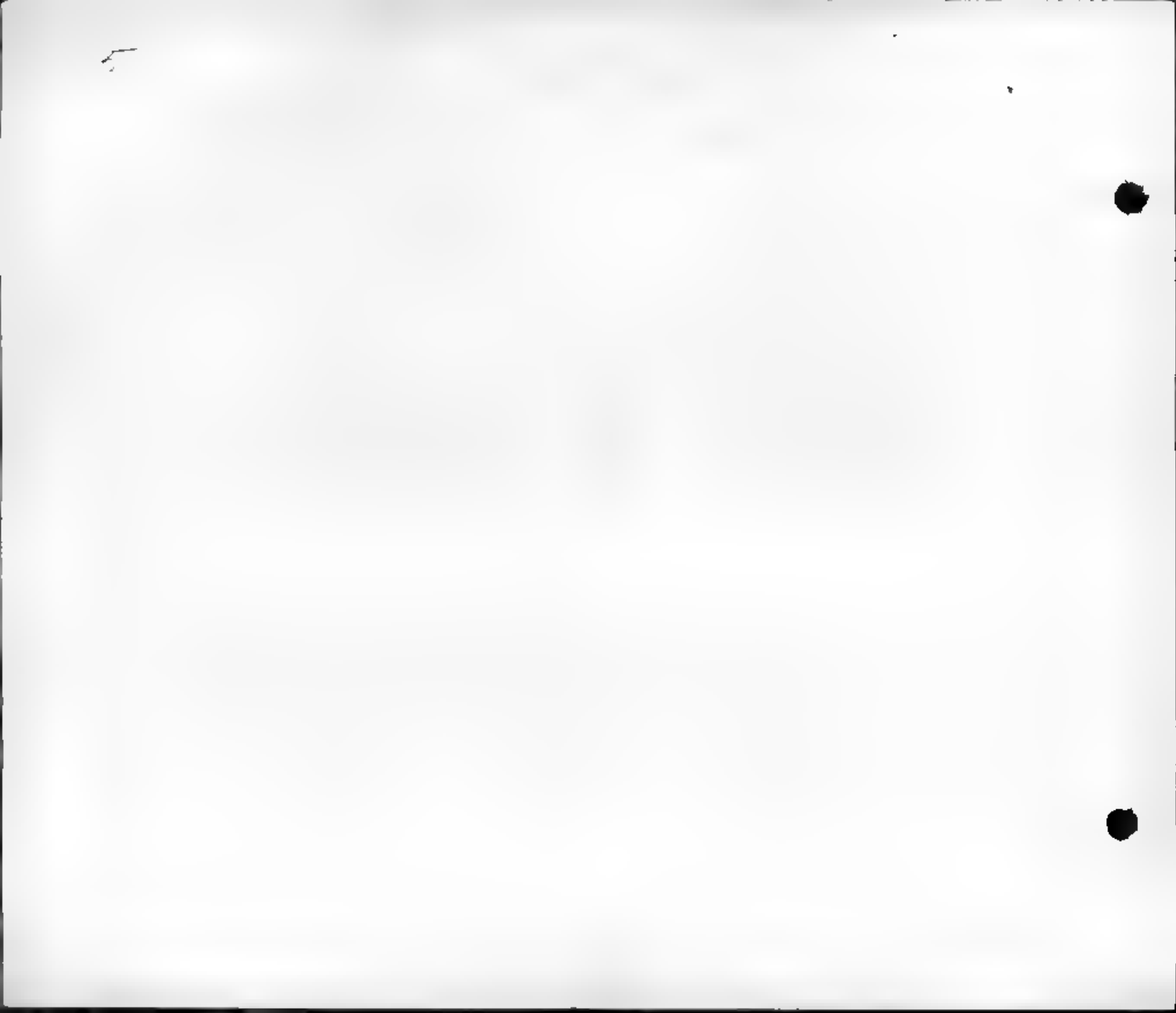
Reg Dist No. 61

Item 7. File # 6181 5-19-55 et

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essey</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essey</u> STREET ADDRESS (If rural give location) <u>33 Pilezan Ave, 21st</u>	
3 NAME OF DECEASED (First, Middle, Last) <u>Leta Elizabeth Titson</u> 4 DATE OF DEATH (Month, Day, Year) <u>May 12 1955</u> 5 SEX <u>F</u> 6 COLOR OR RACE <u>W.</u> 7 SINGLE MARRIED <u>Married</u> 8 DATE OF BIRTH <u>July 7, 1890</u> 9 AGE last birthday <u>64</u> yrs. 10 UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>		11 BIRTHPLACE (State or foreign country) <u>North Carolina</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Casper Hessel</u> 14 MOTHER'S MAIDEN NAME <u>Mrs. Christine Hays</u> 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16 SOCIAL SECURITY NO. <u>20</u> 17 INFORMANT & ADDRESS <u>Walter Hays 235 Taylor St</u>		18 MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331x</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE (B) <u>Mitral Stenosis + Regurgitation</u> DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Hypertension</u>	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19A DATE OF OPERATION <u>C</u> 19B MAJOR FINDINGS OF OPERATION		21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 21B PLACE (Home, farm, factory, street, office bldg, etc.) 21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D TIME (Month, Day, Year) (Hour) OF INJURY <u>M</u> 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21F HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>May 12, 1955</u> , to <u>May 12, 1955</u> , that I last saw the deceased alive on <u>May 12, 1955</u> , and that death occurred at <u>4 P M</u> , from the causes and on the date stated above. SIGNATURE <u>Morris G. Jacob</u> ADDRESS <u>1010 North Point Rd</u> DATE SIGNED <u>May 13, 1955</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>5-16-55</u> NAME OF CEMETERY OR CREMATORY <u>Mount Hope Redeemer</u> LOCATION <u>Baltimore</u> (City, town, or county) (State)		24 FUNERAL DIRECTOR <u>Christine Hays</u> ADDRESS <u>1407 East 2nd St</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-13-55</u> REGISTRAR'S SIGNATURE <u>J. W. Hedden</u>		25	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04377

Reg. Dist. No.

Item 12, Film G182 6-2-55 et

1. PLACE OF DEATH COUNTY <u>Balto. Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Liberty Parkway</u>		STREET ADDRESS (If rural, give location) <u>38 Liberty Parkway</u>	
3. NAME OF DECEASED (Type or Print) <u>Eleonore</u> (First) <u>Lizynski</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>About 1879</u>
9. AGE last birthday <u>about 75 yrs.</u>		10. If under 1 year If under 24 hrs Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leokadya Koprowski</u>		14. MOTHER'S MAIDEN NAME <u>Maryanna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Leonard Lizynski 38 Liberty Parkway</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Coronary Thrombosis</u>		<u>3 days</u>
(b) Antecedent cause(s) <u>Hypertension Cardio-vascular disease</u>		<u>5 yrs</u>
(c) <u>Generalized arterio-sclerosis</u>		
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept, 1954 to May 27, 1955, that I last saw the deceased alive on May 27, 1955, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

SIGNATURE Engene F. Nurn M.D. ADDRESS 2001 Mornington Rd Dundalk, Md. DATE SIGNED May 31, 1955

23. BURIAL CREMATION REMOVAL (Specify) Burial DATE THEREOF May 31, 1955 NAME OF CEMETERY OR CREMATORY Holy Rosary LOCATION (City, town, or county) Balto. Co. Md.

DATE REC'D BY LOCAL REG. May 28 1955 REGISTRAR'S SIGNATURE R.W. 24. FUNERAL DIRECTOR Wm. S. Fralkowski ADDRESS 2007 Eastern Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. 2. 3. 4. 5.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04378

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>617 GEORGE STREET</u>	
3 NAME OF DECEASED (Type or Print) <u>STEWART (NMI) GREEN</u>		4 DATE OF DEATH <u>MAY 12 1955</u>	
5 SEX <u>MALE</u>		6 AGE last birthday <u>59 yrs</u>	
7 COLOR OR RACE <u>COLORED</u>		8 DATE OF BIRTH <u>6-22-95</u>	
9 SINGLE MARRIED <u>MARRIED</u>		10 DATE OF BIRTH <u>6-22-95</u>	
11A USUAL OCCUPATION Give kind of work done during most of working life. (even if retired) <u>LABORER</u>		11B KIND OF BUSINESS OR INDUSTRY <u>RAILROAD CO.</u>	
12 FATHER'S NAME <u>FRANK GREEN</u>		13 BIRTHPLACE (State or foreign country) <u>ALTOONA, PENNSYLVANIA</u>	
14 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		15 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16 SOCIAL SECURITY NO. <u>217-01-0892</u>		17 MOTHER'S MAIDEN NAME <u>ANNIE GREEN</u>	
18 MEDICAL CERTIFICATION		19 INFORMANT'S ADDRESS <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CARCINOMA OF LEFT LUNG</u>		7 MONTHS	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
21A DATE OF OPERATION <u>2/25/55</u>		21B MAJOR FINDINGS OF OPERATION <u>EXPLORATORY THORACOTOMY</u>	
22A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)		22B PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg, etc. <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>	
22C WHERE DID INJURY OCCUR? (City or town, County, State)		22D TIME (Month, Day, Year, Hour) OF INJURY <u>MAY 12 1955</u>	
22E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		22F HOW DID INJURY OCCUR?	
23 I hereby certify that I attended the deceased from FEB. 8, 1955, to MAY 12, 1955, and that death occurred at 6:20 A.M. from the causes and on the date stated above			
SIGNATURE <u>William B. Vandegriest, M.D.</u>		DATE SIGNED <u>5/13/55</u>	
23A BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23B DATE THEREOF <u>5/16/1955</u>	
23C NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		23D LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>	
23E DATE REC'D BY LOCAL REGISTRAR <u>May 16, 1955</u>		23F REGISTRAR'S SIGNATURE <u>A. W. Hedgcock</u>	
23G FUNERAL DIRECTOR <u>ARLINGTON S. PHILLIPS</u>		23H ADDRESS <u>1808 N. MONROE ST BALTIMORE, MARYLAND</u>	



44-2

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL) <u>Lutherville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>		STREET ADDRESS (If rural give location)	
3 NAME OF DECEASED (Type or Print) <u>ARTHUR L. GRISWOLD</u>	4 DATE (Month) <u>May</u> Day <u>4</u> , Year <u>1955</u>		
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 SINGLE MARRIED <u>widowed</u>	8 DATE OF BIRTH <u>May 29, 1865</u>
9 AGE last birthday <u>89</u>	10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk(rtd)</u>	10B KIND OF BUSINESS OR INDUSTRY <u>State of Connecticut</u>	11 BIRTHPLACE (State or foreign country) <u>Connecticut</u>
12 CITIZEN OF WHAT COUNTRY?	13 FATHER'S NAME <u>Orville B. Griswold</u>	14 MOTHER'S MAIDEN NAME <u>Louisa Wight</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u>	16 SOCIAL SECURITY NO.	17 INFORMANT & ADDRESS <u>Mrs. Albert Lathand-Cockeysville, Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>332X</u>			
ANTECEDENT CAUSE (S) <u>DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>0</u>	19B MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOT BY MEDICAL EXAMINER)	21B PLACE (Home, farm, factory, street, office bldg, etc.)	21C WHERE DID INJURY OCCUR?	(County) (State)
21D TIME (Month) Day Year Hour OF INJURY	21E INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> At work <input type="checkbox"/> Not at work <input type="checkbox"/>	21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/4, 1955</u> , to <u>5/4, 1955</u> , that I last saw the deceased alive on <u>5/4, 1955</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harry F. Heinfield</u>		ADDRESS <u>MD 1101 N. Calvert St. Balto.-2, Md.</u>	
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>5/9-55</u>	NAME OF CEMETERY OR CREMATORY <u>Wilimantic</u> LOCATION (City, town, or county) <u>Wilimantic, Conn.</u>	
DATE RECD BY LOCAL REGISTRAR <u>5/6/55</u>	REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	24 FUNERAL DIRECTOR <u>J.M. Fickner</u>	ADDRESS <u>4000 Balto.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No

1 PLACE OF DEATH, COUNTY <u>Baltimore</u> MARYLAND STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		2 USUAL RESIDENCE (HOME) OF DECEASED CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>UNKNOWN</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>UNKNOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>UNKNOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>UNKNOWN</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. Box 767</u>	
3 NAME OF DECEASED (First) (Middle) (Last) <u>JACK GUSYKIEWICZ</u>		4 DATE OF DEATH (Month) (Day) (Year) <u>May 2 19 55</u>	
5 SEX: <u>Male</u>	6 COLOR OR RACE: <u>White</u>	7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8 DATE OF BIRTH: <u>70</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>U</u>		9b. KIND OF BUSINESS OR INDUSTRY: <u>U</u>	
10a. BIRTHPLACE (State or foreign country)		10b. CITIZEN OF WHAT COUNTRY?	
11 FATHER'S NAME: <u>n</u>		12 MOTHER'S MAIDEN NAME: <u>k</u>	
13 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>U</u>		14 SOCIAL SECURITY NO. <u>U</u>	
15 INFORMANT & ADDRESS: <u>U</u>		16	
17 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>Arteriosclerotic cardiovascular disease</u>		18 MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION: <u>U</u>		19b. MAJOR FINDING OF OPERATION: <u>U</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
20c. CITY or town (County) (State)		20d. HOW DID INJURY OCCUR?	
21. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> D TO SIGNED <input checked="" type="checkbox"/> 5/3/55	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremated</u>		24. FUNERAL DIRECTOR <u>U</u>	
DATE REC'D BY LOCAL REG. <u>June 9, 1955</u>		25. ADDRESS <u>U</u>	

ARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44-3
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45
 04360

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	
TOWN <u>Essex</u>	<u>34</u>	TOWN <u>Essex</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 S. Taylor.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		DATE OF DEATH	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>George Frederick Gutmuth</u>	<u>Gutmuth</u>	<u>May 16</u>	<u>1951</u>
4. SEX	5. COLOR OR RACE	7. SINGLE, MARRIED, WIDOW, DIVORCED (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 29/1904</u>
			9. AGE last birthday. <u>51</u> yrs. <u>5</u> months <u>16</u> days <u>0</u> hours <u>0</u> min.
10a. USUAL OCCUPATION (Give kind of work done during part of work life)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
<u>Deputy Sheriff, Balto., Co.</u>	<u>Balto., Co.</u>	<u>Baltimore, Md.</u>	<u>U.S.A.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Otto Gutmuth</u>		<u>Eleanor Gutf.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>705-10-9203</u>	
17. INFORMANT & ADDRESS			
<u>Donald Gutmuth (Son)</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) DUE TO <u>Coronary occlusion</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION.			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> (State)
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21c. (City or town) County:			
21d. TIME (Month) (Day) (Year) (Hour) (Minute) <u>May 5-16-55 1:45 PM</u>			21e. INJURY OCCURRED White at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			23. HOW DID INJURY OCCUR?
SIGNATURE <u>J. McQuinn M.D.</u>			CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>			DATE SIGNED
DATE RECEIVED BY LOCAL REG. <u>5/21/55</u>			24. FUNERAL DIRECTOR
REGISTRAR'S SIGNATURE <u>Gold Hurlay</u>			ADDRESS <u>Baltimore Funeral Home 7401 Belair Rd</u>

31 1500

1500

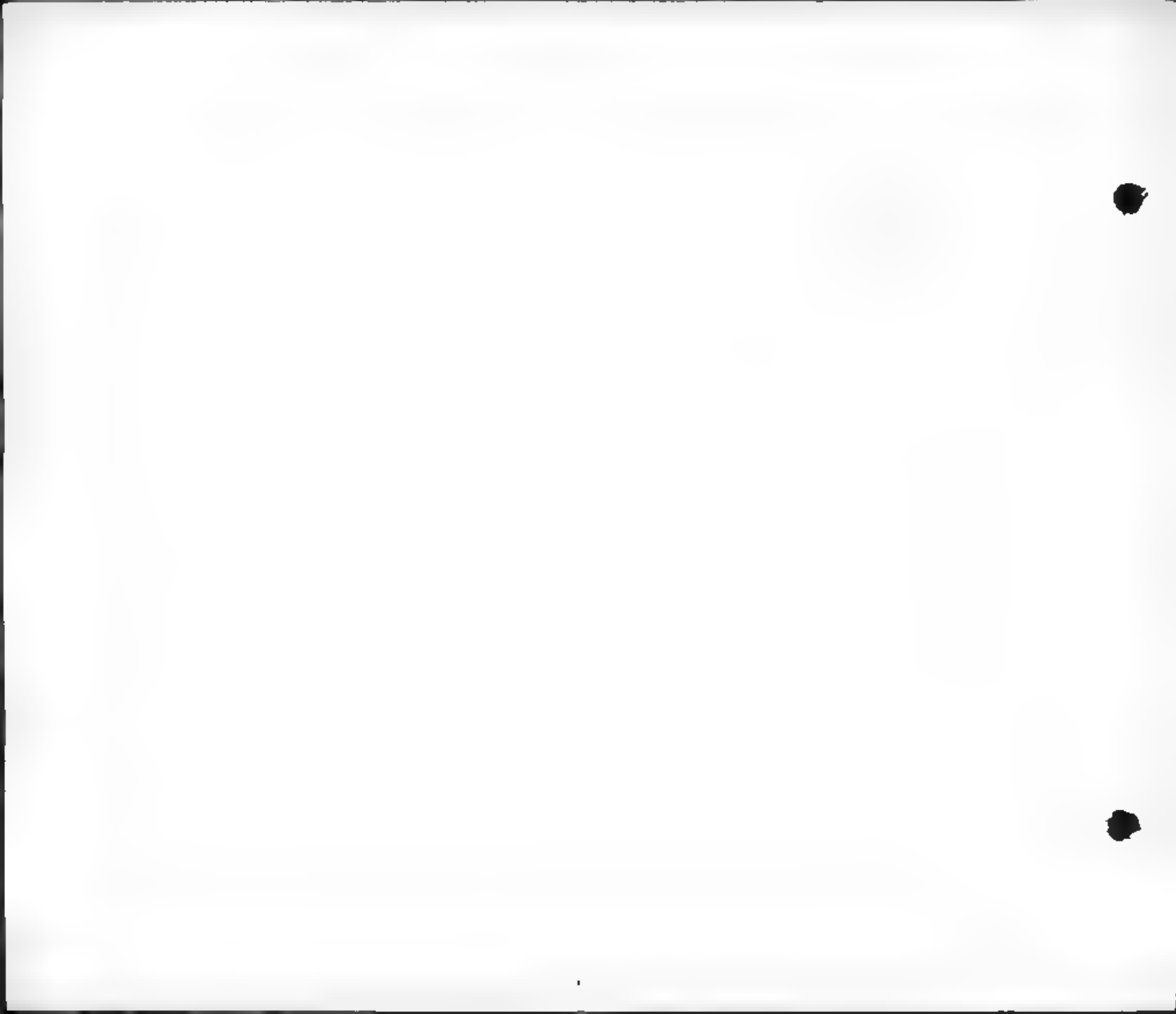
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44-4 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04381

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u> 11 YRS HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4201 PRAGUE AVE</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LIVERLEA</u> STREET ADDRESS (If rural give location) <u>4201 PRAGUE AVE</u>	
3 NAME OF DECEASED (First) <u>AGNES</u> (Middle) <u>THERESA</u> (Last) <u>HAGAN</u> Type or Print:		4 DATE (Month) (Day) (Year) OF DEATH <u>MAY 21 1955</u>	
5 SEX <u>FEMALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 SINGLE MARRIED <u>WIDOWED</u> 8 DATE OF BIRTH <u>MAY 14 1885</u> 9 AGE last birthday <u>70</u> yrs (Specify)		10A USUAL OCCUPATION Give kind of work done during most of working life even if retired <u>HOUSEWIFE</u> 10B KIND OF BUSINESS OR INDUSTRY <u>NONE</u> 11 BIRTHPLACE (State or foreign country) <u>BOSTON MASS</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>PETER M. CURRAN</u>		14 MOTHER'S MAIDEN NAME <u>MARY A. REILEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) If Yes, give war or dates of service <u>NO</u>		16 SOCIAL SECURITY NO. <u>4-2-0</u> 17 INFORMANT & ADDRESS <u>CHARLES W. FOWLER 4201 PRAGUE AVE</u>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u> ANTECEDENT CAUSE (B) <u>CEREBRAL ARTERIO SCLEROSIS</u> DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS</u> <u>10 YRS</u>
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)		21B PLACE (Home, farm, factory, office bldg, etc.) OF INJURY	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)		21E INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/24</u> , 19 <u>55</u> , to <u>5/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>55</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above SIGNATURE <u>[Signature]</u> ADDRESS <u>MD 6331 Belair Rd</u> DATE SIGNED <u>5/23/1955</u>			
23 BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> DATE REC'D BY LOCAL REGISTRAR <u>3/23/55</u>		DATE THEREOF <u>MAY 24 1955</u> NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u> LOCATION (City, town or county) (State) <u>BELAIR RD</u> REG STRAR'S SIGNATURE <u>A.W. Hedrick</u> 24 FUNERAL DIRECTOR <u>Coffel Brothers</u> ADDRESS <u>7110 BELAIR RD</u>	



4405

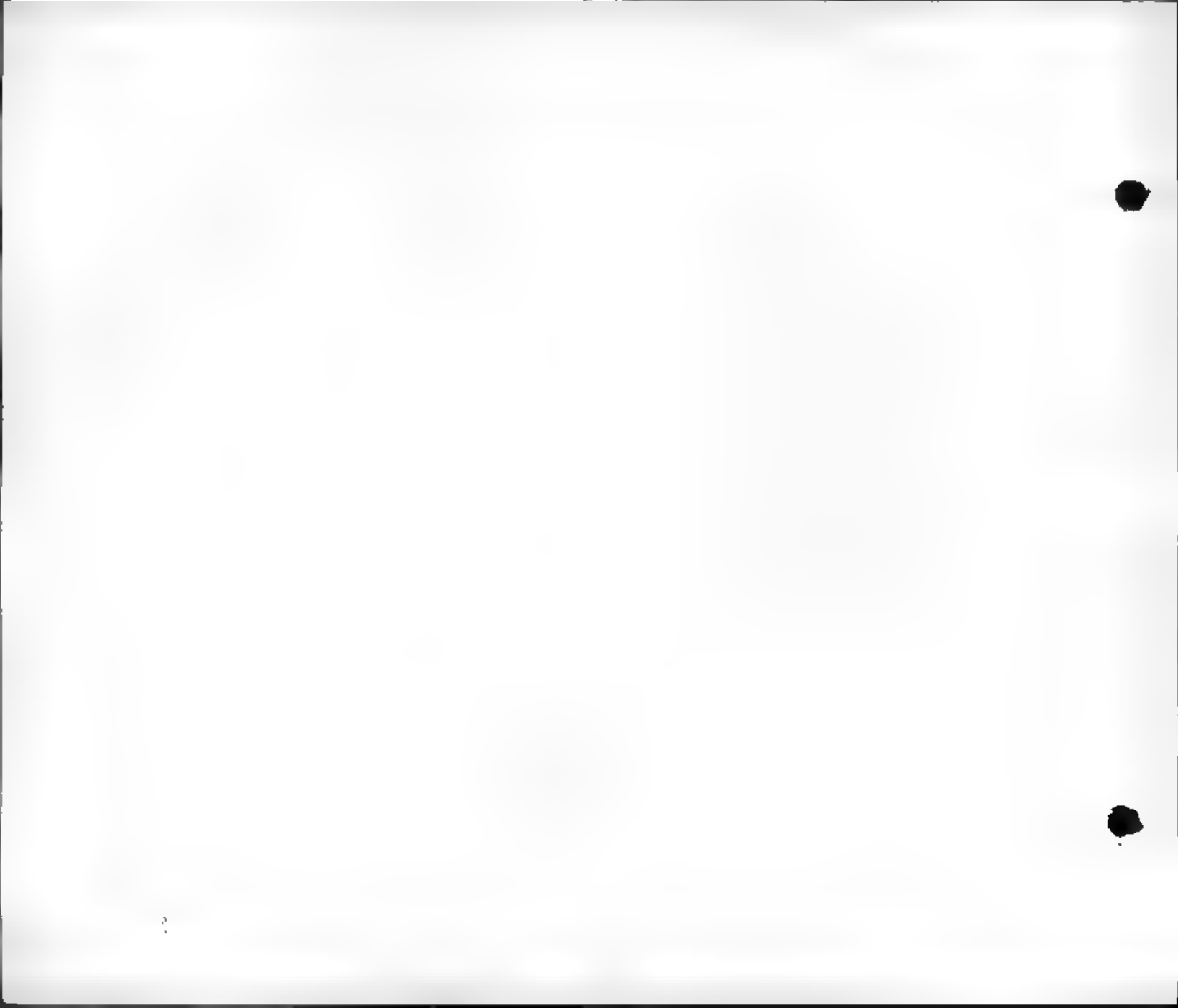
CERTIFICATE OF DEATH

Reg. Dist. No. 04382 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>1st</u>
CITY (If outside corporate limits, write RURAL, LENGTH OF STAY in this place) <u>45 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town OR TOWN <u>Baltimore Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8915 Heile Lane</u>		STREET ADDRESS (If rural, give location) <u>8915 Heile Lane</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print) <u>Margarette Hale</u>		(Month) (Day) (Year) <u>5/17 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>April 7, 1873</u>
9. AGE last birthday: <u>82</u> yrs.		10. IF UNDER 1 YEAR: <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Bedford Co. Va</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Amos</u>		14. MOTHER'S MAIDEN NAME: <u>Mormon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Mauda Jenkins 8915 Heile Lane</u>			
18. MEDICAL CERTIFICATION			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>Myocardial Insufficiency</u>			
Interval Between Onset And Death: <u>Irregularity & arteriosclerosis</u>			
19. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SLICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1954</u> to <u>May 1955</u> , that I last saw the deceased alive on <u>May 1955</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE OF REGISTRAR: <u>Frank P. Kaul</u>		DATE SIGNED: <u>5/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF: <u>May 20/55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Mt. Calvary Cem.</u>		LOCATION (City, town, or county) (State): <u>A. A. County Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>5-18-55</u>		REGISTRAR'S SIGNATURE: <u>A. W. Hedrick</u>	
24. FEDERAL DIRECTOR: <u>Mr. R. H. O. Elliot</u>		ADDRESS: <u>1129 N. Caroline St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg Dist. No.

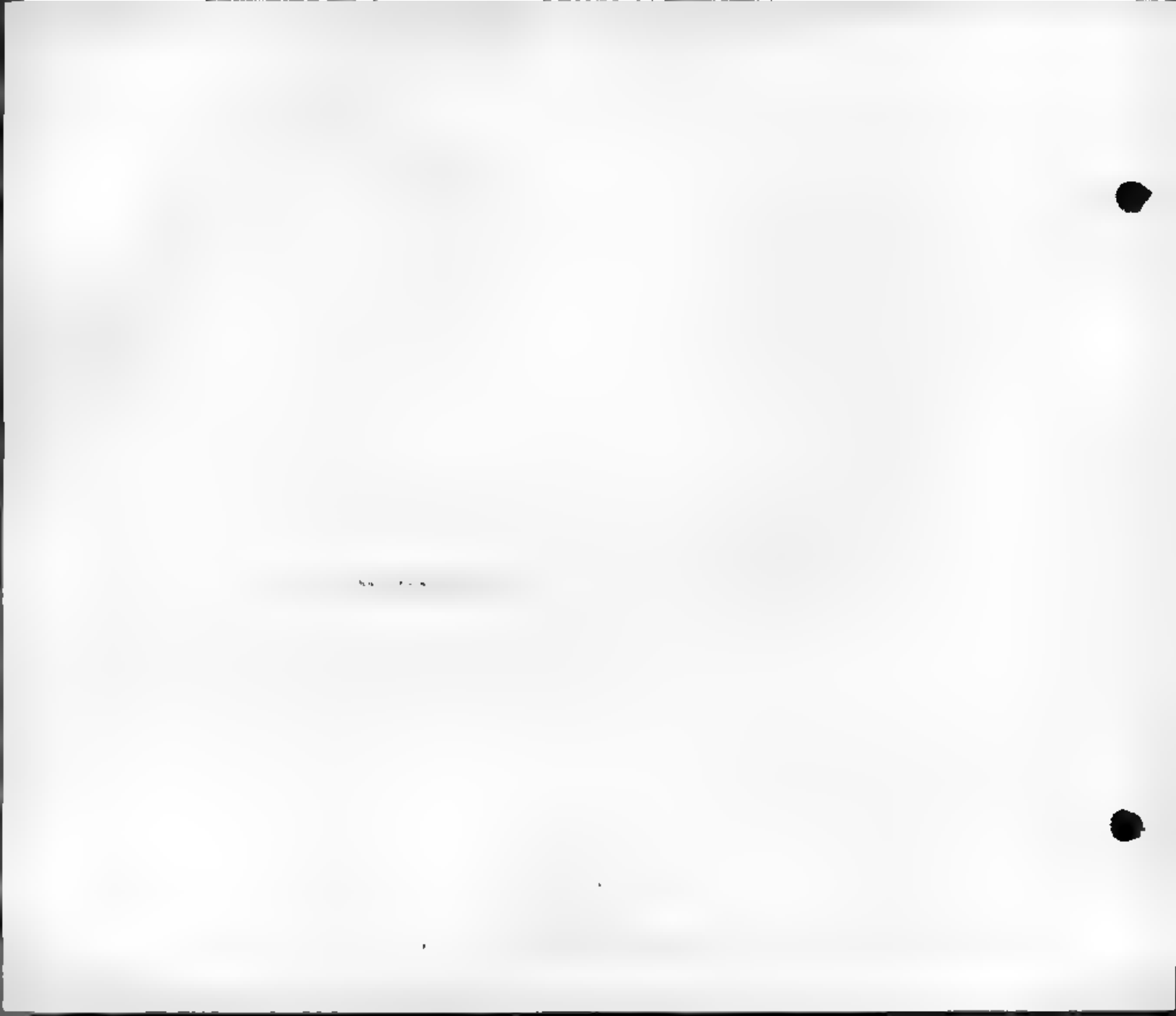
4426

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Catonsville</u> TOWN <u>Myr. Homes, 6 days</u>		STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u> TOWN _____	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Spring Grove State Hosp.</u>		STREET ADDRESS (If rural give location) <u>942 S. Poca St.</u>	
3 NAME OF DECEASED (Type or Print) <u>Flora Harper</u>		4. DATE (Month) (Day) (Year) <u>May 1, 1955</u>	
5 SEX <u>Female</u> 6 COLOR OR RACE <u>White</u> 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> 8 DATE OF BIRTH <u>March 25, 1867</u> 9. AGE (last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months, Days, Hours, Min.			
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u> 10B KIND OF BUSINESS OR INDUSTRY _____		11 BIRTHPLACE (State or foreign country) <u>Canada</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA (Naturalized)</u>	
13 FATHER'S NAME <u>No record</u>		14 MOTHER'S MAIDEN NAME <u>No record</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If Yes, give war or dates of service) _____		16 SOCIAL SECURITY NO. _____	
17 INFORMATION & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u> DUE TO _____		5 min.	
ANTECEDENT CAUSE (B) <u>Terminal cardiorespiratory failure</u> DUE TO _____		Several hours	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Bronchopneumonia - bilateral</u>		10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Generalized arteriosclerosis</u>		Years	
19A DATE OF OPERATION _____ 19B. MAJOR FINDINGS OF OPERATION _____		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MED. EXAMINER) _____		21B PLACE (Home, farm, factory, street, office bldg., etc.) _____	
21C WHERE DID INJURY OCCUR? City or town _____ (County) _____ (State) _____			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E INJURY OCCURRED _____ 21F HOW DID INJURY OCCUR? _____	
21G _____			
22 I hereby certify that I attended the deceased from <u>June 11, 1953</u> to <u>May 1, 1955</u> ; that I last saw the deceased alive on <u>April 30, 1955</u> , and that death occurred at <u>5:35 A.M.</u> , from the causes and on the date stated above			
SIGNATURE <u>John P. Risley M.D.</u>		DATE SIGNED <u>5/1/55</u>	
23 BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u> DATE THEREOF <u>MAY 4, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u> LOCATION (City, town, or county) <u>Elkridge, Md.</u>		24 FUNERAL DIRECTOR <u>John O. Mitchell</u> ADDRESS <u>1900 Euteria Pl.</u>	
DATE RECD BY LOCAL REGISTRAR <u>3-11-55</u>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4497

CERTIFICATE OF DEATH

Reg. Dist. No.

04384

37

1 PLACE OF DEATH					2 USUAL RESIDENCE HOME OF DECEASED					
COUNTY <u>Baltimore</u> MARYLAND					STATE <u>Md</u> COUNTY <u>Baltimore</u>					
CITY (If outside corporate limits, write RURAL and give nearest town)					CITY (If outside corporate limits, write RURAL and give nearest town)					
TOWN <u>Cockeysville</u> 14 yrs					TOWN <u>Baltimore</u>					
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Masonic Home</u>					STREET ADDRESS <u>1302 Morling Cr.</u>					
3 NAME OF (First) (Middle) (Last)					4 DATE (Month) (Day) (Year)					
Type or Print <u>Ossola Harper</u>					OF DEATH <u>May 13 1955</u>					
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 SINGLE MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8 DATE OF BIRTH <u>Aug 18 - 1870</u>		9 AGE (last birthday) <u>84</u> yrs. <u>9</u> months <u>9</u> days <u>9</u> hours <u>9</u> min		
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife own home</u>					10B KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>East City Md.</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>James W. Torne</u>					14 MOTHER'S MAIDEN NAME <u>Ummie Troop</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) If Yes, give war or dates of service					16 SOCIAL SECURITY NO <u>None</u>		17 INFORMANT & ADDRESS <u>Anna M. Schroeder</u>			
18 MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										
IMMEDIATE CAUSE (A) <u>422.1 Cardio Vascular Disease</u>										
ANTECEDENT CAUSE (B) <u>Arterio-sclerotic</u>										
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>and 5 yrs</u>										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH										
19A DATE OF OPERATION <u>0</u>			19B MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21B PLACE (Home, farm, factory or injury street, office bldg., etc.)			21C WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21D TIME (Month) (Day) (Year) (Hour) OF INJURY			21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21F HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>3/15, 1945</u> to <u>May 13, 1954</u> that I last saw the deceased alive on <u>May 13, 1955</u> , and that death occurred at <u>9:35 AM</u> , from the causes and on the date stated above.										
SIGNATURE <u>Walter T. Lee</u>					ADDRESS <u>M.D. Cockeysville Md</u>		DATE SIGNED <u>May 13/55</u>			
23 BURIAL, CREMATION REMOVAL (SPECIFY) <u>5/16/55 - Golden Pk</u>			NAME OF CEMETERY OR CREMATORY <u>Baltimore Md</u>			LOCATION (City, town, or county) <u>Md</u>				
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE <u>Anna M. Schroeder</u>			24 FUNERAL DIRECTOR ADDRESS <u>Wm. Cook, St Paul & Union St</u>				

3 A OVER

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL) LENGTH OF STAY OR TOWN FORT HOWARD 20 days HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STATE MARYLAND COUNTY DORCHESTER CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CAMBRIDGE 09-11-55 STREET ADDRESS (If rural give location) 313 PINE STREET			
3 NAME OF DECEASED (First) (Middle) (Last) CHARLES E. HARRIS				4 DATE OF DEATH (Month) (Day) (Year) MAY 21 19 55			
5 SEX MALE 6 COLOR OR RACE COLORED 7 SINGLE MARRIED WIDOWED DIVORCED (Specify) SINGLE 8 DATE OF BIRTH 9-14-08 9 AGE last birthday 46 yrs 10 UNDER 1 YEAR 11 UNDER 24 HRS Months Days Hours Min							
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) LABORER 10B KIND OF BUSINESS OR INDUSTRY FOOD PACKING 11 BIRTHPLACE (State or foreign country) CAMBRIDGE, MARYLAND 12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13 FATHER'S NAME: EDWARD HARRIS				14 MOTHER'S MAIDEN NAME ELLA PERRY			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-11 16 SOCIAL SECURITY NO 312-16-7153 17 INFORMANT & ADDRESS CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.							
18 MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 Months			
IMMEDIATE CAUSE (A) TUBERCULOUS PERITONITIS DUE TO							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C)							
19 HER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A DATE OF OPERATION 19B MAJOR FINDINGS OF OPERATION				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 21B PLACE (Home, farm, factory, street, office bldg., etc) 21C WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21D TIME (Month) (Day) (Year) (Hour) OF INJURY 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 21F HOW DID INJURY OCCUR?							
22 I hereby certify that I attended the deceased from May 1, 1955, to May 21, 1955, and that death occurred at 4:00 PM, from the causes and on the date stated above.							
SIGNATURE WILLIAM B. VANDEGRIFT, M.D. ADDRESS M.D. VAH, Fort Howard, Md. DATE SIGNED 5/22/55							
23 BURIAL CREMATION REMOVAL (SPECIFY) BURIAL DATE THEREOF 5/25/55 NAME OF CEMETERY OR CREMATORY Cambridge Bethel Cemetery LOCATION (City, town or county) Cambridge, Maryland							
24 FUNERAL DIRECTOR ADDRESS Arlington S. Phillips Funeral Home							

MARGIN RESERVED FOR BINDING

U.S. A15-10-53

SHIPPED BY

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

44 '9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04386

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u> TOWN <u>Sparrows Point</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2549 Lodge Forrest Drive</u>				2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u> OR TOWN <u>Colgate</u> STREET ADDRESS (If rural, give location) <u>Riverside Avenue</u>			
3 NAME OF DECEASED (First) (Middle) (Last) <u>Margaret A. Harris</u>				4 DATE OF DEATH (Month) (Day) (Year) <u>May 1, 1955</u>			
5 SEX <u>female</u>		6 COLOR OR RACE <u>white</u>		7 SINGLE MARRIED WIDOWED DIVORCED <u>widowed</u>		8 DATE OF BIRTH: <u>About Sept. 1877</u>	
9 AGE (last birthday) <u>77</u> yrs		10 UNDER 1 YEAR Months Days Hours Min.		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>				10B KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13 FATHER'S NAME <u>unknown</u>				14 MOTHER'S MAIDEN NAME <u>unknown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT & ADDRESS <u>Maurice Pressman, 1102 Court Square Bldg.</u>	
18 MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (A) <u>Cerebral Hemorrhage</u> DUE TO (B) <u>Hypertensive C.V. Disease</u> DUE TO (C)						<u>24 hrs</u> <u>5 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A DATE OF OPERATION <u>7</u>				19B MAJOR FINDINGS OF OPERATION			
20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21B PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C WHERE DID CITY or town (County) (State) INJURY OCCUR?	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 1, 1955</u> , to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>May 1, 1955</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above. SIGNATURE <u>James G. Means</u> ADDRESS <u>520 D St. Baltimore</u> DATE SIGNED <u>5/2/55</u> M D							
23 A. R. A. L CREMATION REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>5/4/55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-2-55</u>		REGISTRAR'S SIGNATURE <u>A. W. [illegible]</u>		24 FUNERAL DIRECTOR <u>Wm. Gork. Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

04387

4332

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7703 MEATH ROAD</u>		STREET ADDRESS (If rural, give location) <u>7703 MEATH RD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ERNEST</u> (Middle) <u>ISAAC</u> (Last) <u>HARTER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>5-11-53</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify widowed) <u>WIDOWED</u>	8. DATE OF BIRTH <u>27 FEB. 1871</u>
9. AGE last birthday <u>84</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC HARTER</u>		14. MOTHER'S MAIDEN NAME <u>CHARLES (WVA)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WAYNARD E. HARTER - SON</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Arterio Sclerotic Cardiac Insulin</u>		
(b) Antecedent cause(s) <u>Senility</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19. DATE OF OPERATION	20. MAJOR FINDINGS OF OPERATION	21. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
22. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE <u>W. J. Brown</u> (Degree or title)		DATE SIGNED <u>5/14/53</u>	
23. BURIAL (CREMATION) (Specify) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>CAR HILL</u>	
DATE THEREOF <u>5/14/53</u>		LOCATION (City, town, or county) (State) <u>HERKIMER, N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>1-155</u>		24. FUNERAL DIRECTOR'S ADDRESS <u>White House, Dundalk, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

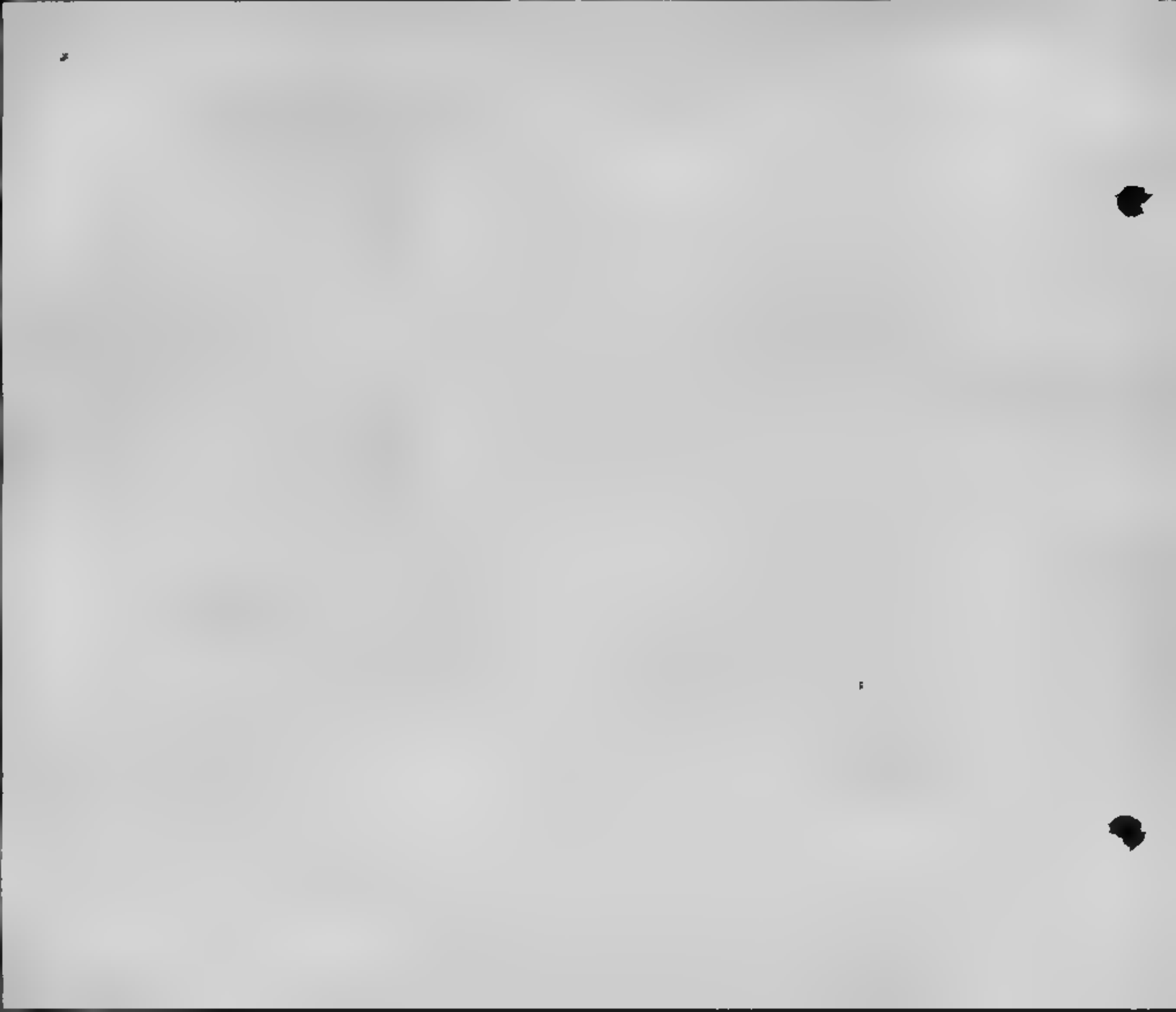
4419

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04388
Reg. Dist.

1 PLACE OF DEATH:		2 USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 4, 1 mile N. E. Greener Rd.</u>		STREET ADDRESS (If rural, give location) <u>1956 Third St., N.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLOTTE</u>	(First) <u>A.</u> (Middle) <u>HAYES</u> (Last)	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>6</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH: <u>JAN 27, 1927</u>		9. AGE last birthday: <u>28</u> yrs (Month) <u>2</u> (Day) <u>1</u> (Year) <u>1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JULIAN JAMES COOKE</u>		14. MOTHER'S MAIDEN NAME: <u>ELSIE PATRICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No: <u>YES</u>	
17. INFORMANT & ADDRESS: <u>MR. JOHN T HAYES 1956 3rd St. N.E. Wash. D.C.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Multiple extreme injuries of body DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
Adding underlying cause last (c)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Acute alcoholism</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AL TOPOSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>street</u>	
21c. CITY or town (County) (State): <u>Rt. 40 Balto. Md.</u>			
21d. TIME Month, Day, Year (Hour) OF INJURY: <u>5/6/55 M</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Driver of auto struck culvert</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>May 6, 1955</u>	
23. BURIAL CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>May 10, 1955</u>	
NAME OF CEMETERY OR CREMATORY: <u>FORESTVILLE EPH. CEMETERY FORESTVILLE, MD</u>		LOCATION (City, town or county) <u>WASH D.C.</u>	
DATE READ BY LOCAL REG. <u>1955</u>		24. FUNERAL DIRECTOR: <u>W. L. CHAMBERS</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

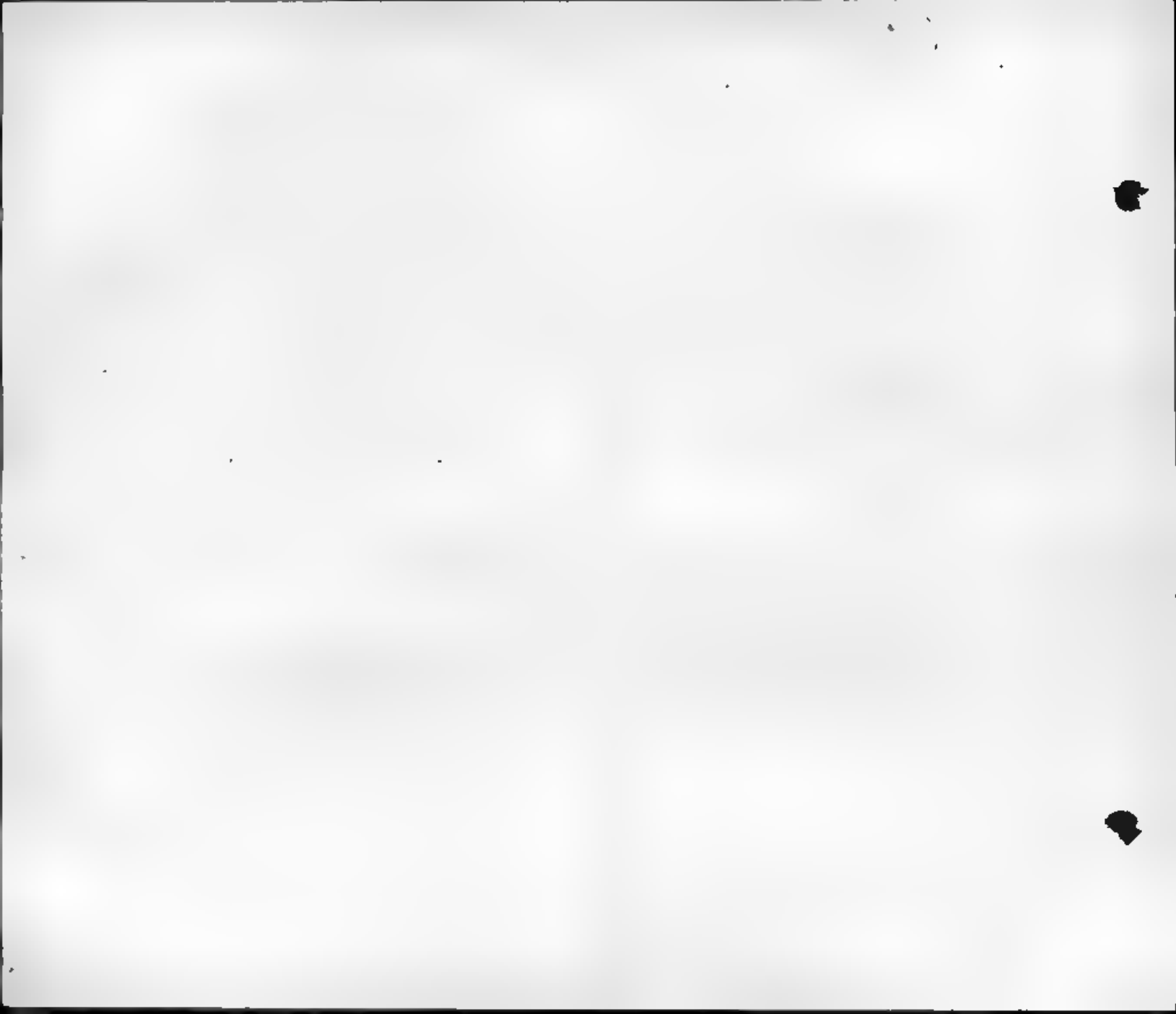
04389

4411

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND CITY (if outside corporate limits write RURAL) <u>PORT HOWARD</u> LENGTH OF STAY <u>47 DAYS</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STATE <u>MARYLAND</u> COUNTY CITY (if outside corporate limits write RURAL and give nearest town, OR TOWN <u>BALTIMORE</u> STREET ADDRESS (if rural give location) <u>1119 LAURENS STREET</u>			
3 NAME OF DECEASED (First) (Middle) (Last) <u>JOHN JOSEPH HEFNER</u>				4 DATE (Month) (Day) (Year) OF DEATH <u>MAY 3 1955</u>			
5 SEX <u>MALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 SINGLE MARRIED <u>MARRIED</u> 8 DATE OF BIRTH <u>5-29-98</u>				9 AGE last birthday <u>56</u> 10 SEX <u>MALE</u> 11 MONTHS <u>3</u> 12 HOURS <u>3</u> 13 MIN. <u>1955</u>			
10A USUAL OCCUPATION (give kind of work done during most of working life even if retired) <u>PRODUCE WORK</u>				10B KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>			
11 FATHER'S NAME <u>JOHN HEFNER</u>				12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If Yes, give war or dates of service) <u>WW I</u>				14 MOTHER'S M.A.DEN NAME <u>ANNIE SMITH</u>			
15 SOCIAL SECURITY NO. <u>UNKNOWN</u>				17 INFORMANT'S ADDRESS <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION							
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>199.9 METASTATIC CARCINOMA, PRIMARY SITE NOT KNOWN</u>							
ANTECEDENT CAUSE (B) <u>UNKNOWN</u>							
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>UNKNOWN</u>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>GENERALIZED ARTERIOSCLEROSIS</u>							
21. DATE OF OPERATION <u>4-15-55</u> 22. MAJOR FINDINGS OF OPERATION <u>EXCISION OF TISSUE FROM LESION OF RIGHT SCAPULA</u>							
23. DATE OF OPERATION <u>4-15-55</u> 24. MAJOR FINDINGS OF OPERATION <u>EXCISION OF TISSUE FROM LESION OF RIGHT SCAPULA</u>							
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner) 26. PLACE (Home, farm, factory, etc.) OF INJURY OCCURRED 27. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
28. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY 29. NATURE OF INJURY OCCURRED 30. HOW DID INJURY OCCUR?							
31. I hereby certify that I attended the deceased from <u>MAR. 17, 1955</u> to <u>MAY 3, 1955</u> and that death occurred at <u>1:30AM</u> from the causes and on the date stated above.							
32. SIGNATURE OF PHYSICIAN <u>Francis G. Dickey, M.D.</u> ADDRESS <u>M. O. VAN, FORT HOWARD, MARYLAND 5-3-55</u> DATE SIGNED <u>5/7/55</u>							
33. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>5/7/55</u> NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY</u> LOCATION (City or town or county) <u>BALTIMORE, MARYLAND</u>							
34. DATE REC'D BY LOCAL REGISTRAR <u>5-5-55</u> REGISTRAR'S SIGNATURE <u>Wm. Tickner & Sons, Inc.</u> 35. FUNERAL DIRECTOR'S ADDRESS <u>Baltimore, Maryland</u>							



04390

4412

CERTIFICATE OF DEATH

Reg. Dist. No.

30

MARGIN RESERVED FOR BINDING

VS A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY <u>Catonsville</u>	OR <u>Catonsville</u>	CITY (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	OR <u>Baltimore</u>
TOWN <u>Catonsville</u>	LENGTH OF STAY <u>14</u> days	STREET ADDRESS <u>2611 Washington Blvd.</u>	(If rural, give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>	3 NAME OF DECEASED (First) <u>Herman</u> (Middle) <u>Helwig</u> (Last) <u>Helwig</u>	4. DATE (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1955</u>	OF DEATH
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> (Specify)	8 DATE OF BIRTH <u>9-10-1867</u>
9 AGE last birthday <u>87</u> yrs	10 MONTHS <u>87</u> Days <u>87</u> Hours <u>87</u> Min.	11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13 FATHER'S NAME <u>John Helwig</u>	14 MOTHER'S MAIDEN NAME <u>Louise ?</u>	15 INFORMANT'S ADDRESS <u>Records Spring Grove State Hospital</u>	16. MEDICAL CERTIFICATION
17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4221</u>	(A) <u>Coronary failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>80 days</u>	
IMMEDIATE CAUSE	DUE TO		
ANTECEDENT CAUSE (S) <u>Arteriosclerotic cardiovascular disease</u>	(B) <u>Arteriosclerotic cardiovascular disease</u>	Years <u>Years</u>	
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <u>Cerebrovascular accident</u>	(C) <u>Cerebrovascular accident</u>		
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Generalized arteriosclerosis</u>		Years <u>Years</u>	
19A DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21B PLACE (Home, farm, factory, office, etc.) OF INJURY <u>Spring Grove State Hospital</u>	21C WHERE DID INJURY OCCUR? (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-6-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-11-55</u> , 19 <u>55</u> , and that death occurred at <u>10:15 M</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		DATE SIGNED <u>5-11-55</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>5-15-55</u>	NAME OF CEMETERY OR CREMATORY <u>London Park</u>	LOCATION <u>Frederick Rd Baltimore</u>
DATE REC'D BY LOCAL REGISTRAR <u>May 10, 1955</u>	REGISTRAR'S SIGNATURE <u>A. W. McHugh</u>	24 FUNERAL DIRECTOR <u>Edward Johnson</u>	ADDRESS <u>Baltimore 20 Md</u>



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04391

4413

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>BALTIMORE</u> COUNTY <u>23-52-1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATO RIDGE APT. 1</u>		STREET ADDRESS (If rural, give location) <u>HARLEM LANE - CATONSVILLE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANNA</u> (Middle) <u>VIRGINIA</u> (Last) <u>HESS</u>	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WH</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>W</u>	8. DATE OF BIRTH <u>2/15/75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>5</u> yrs. If under 1 year: Months <u>5</u> Days <u>27</u> Hours <u>19</u> Mins. <u>4</u>
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>THOMAS H. HESS</u>		14. MOTHER'S MAIDEN NAME <u>MARY PUGH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT <u>Mrs. A. HESS</u>		18. MEDICAL CERTIFICATION <u>2208 Taylor Ave Baltimore</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>Respiratory failure</u> Antecedent cause(s) (b) <u>Cancer of Esophagus</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Dehydration & emaciation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u> <u>1 month</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Esophagus removed about 2 months ago at John Hopkins</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>	22. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	23. HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <u>July 1st, 1955</u> , to <u>July 26, 1955</u> , that I last saw the deceased alive on <u>5/26, 1955</u> , and that death occurred at <u>4:40</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Chas. Ratliff, Jr. M.D.</u>		ADDRESS <u>4605 Edmondson Ave Baltimore</u>	
DATE SIGNED <u>5/27/55</u>		DATE SIGNED <u>5/27/55</u>	
24. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>May 30, 1955</u>	<u>Gordwell</u>	<u>Baltimore</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
<u>5/27/55</u>	<u>T.E. Harry</u>	<u>Walter K. K...</u>	<u>Baltimore</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DECEMBER 19, 1904

1904

1904

4414

CERTIFICATE OF DEATH

Reg. Dist. No

1 PLACE OF DEATH

COUNTY Baltimore

CITY If outside corporate limits, write RURAL and give nearest town

TOWN Catonsville

MARYLAND

LENGTH OF STAY (In this place)

HOSPITAL OR
NURSING TUTION OR
STREET ADDRESS

Catonsville Nursing Home

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY

CITY If outside corporate limits, write RURAL and give nearest town

OR TOWN Baltimore

STREET ADDRESS (If rural give location)

unknown

3 NAME OF
DECEASED
(Type or Print)

First

DAISY

(Middle)

C.

Last

HOHMAN

4 DATE (Month)

Day

(Year)

OF DEATH

May

9,

1955

5 SEX

6 COLOR OR RACE

7 SINGLE MARRIED, WIDOWED, DIVORCED

8 DATE OF BIRTH

9 AGE last birthday

10 UNDER 1 YEAR 11 UNDER 24 HRS

Months

Days

Hours

Min

female

white

widowed

Nov. 24, 1869

85

10A USUAL OCCUPATION Give kind of work done during most of working life even if retired

housewife

10B KIND OF BUSINESS OR INDUSTRY

at home

11 BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12 CITIZEN OF WHAT COUNTRY?

U. S. A.

13 FATHER'S NAME

James T. Barker

14 MOTHER'S MAIDEN NAME

unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) If Yes, give war or dates of service

16 SOCIAL SECURITY NO

17 INFORMANT'S ADDRESS

4415 Colesville Road
Harry A. L. Barker, Riverdale, Maryland

18 MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

IMMEDIATE CAUSE

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) DUE TO

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

INTERVAL BETWEEN ONSET AND DEATH

19A DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY?

YES ☐ NO ☐

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either not by medical examiner)

21B PLACE (Home, farm, factory, street, office, bldg, etc.)

21C WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21D TIME (Month, Day, Year, Hour) OF INJURY

21E INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12 1955, to 5-4 1955, that I last saw the deceased alive on 5-4 1955, and that death occurred at 11 M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23 BURIAL, CREMATION, REMOVAL (SPECIFY)

burial

DATE THEREOF

5/12/55

NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

LOCATION (City or town or county)

Baltimore,

Maryland

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

5-10-55

Wm. Bork, Inc., 1217 St. Paul Street

MARGIN RESERVED FOR BINDING



4415

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTO. CO.</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	STATE <u>MD</u> COUNTY <u>BALTO.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>
TOWN <u>CATONSVILLE</u> LENGTH OF STAY (in this place) <u>20 Yrs.</u>	HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 S. ROLLING RD.</u>	STREET ADDRESS (If rural give location) <u>5 S. ROLLING RD.</u>	
3 NAME OF DECEASED (Type or Print) <u>CATHERINE R. HUTTON</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>5/16/55</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 SINGLE MARRIED <u>WIDOWED</u>	8 DATE OF BIRTH <u>APR. 27, 1883</u> 77 yrs Months Days Hours Min
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <u>MD</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>CHAS. J. BLUMENAUER</u>	
14 MOTHER'S MAIDEN NAME <u>MARK T. HUBERT</u>		15 INFORMANT'S ADDRESS <u>Mr. Thurem Lubner</u>	
16 MEDICAL CERTIFICATION		17 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			
ANTECEDENT CAUSE (B) <u>Coronary Arteriosclerosis</u>			
DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Vascular Disease</u>			
10A DATE OF OPERATION <u>6</u>		10B MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B PLACE (Home, farm, factory, street, office bldg., etc.)	
21C TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21D INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21E HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>9/20, 1938</u> , to <u>5/16, 1955</u> that I last saw the deceased alive on <u>9/12, 1955</u> , and that death occurred at <u>1025 M</u> , from the causes and on the date stated above			
SIGNATURE <u>E. J. W. [Signature]</u>		DATE SIGNED <u>5/17/55</u>	
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>LOUDDON PARK</u>		LOCATION (City town or county) <u>BALTO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/18/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24 FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-634

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

4416

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04394

No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	OR TOWN
TOWN <u>Spring Grove State Hosp.</u>	<u>1</u>	TOWN <u>Baltimore</u>	<u>700 / - 4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp.</u>		STREET ADDRESS (If rural, give location) <u>2603 S. Erie Avenue</u>	
3. NAME OF DECEASED.		4. DATE OF DEATH	
(First) <u>Lva</u>	(Middle) <u>Isaacson</u>	(Month) <u>2</u>	(Day) <u>2</u>
(Type or Print)		(Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan 1908</u>
9. AGE last birthday: <u>70</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unknown</u>		
11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME: <u>Michael Berger</u>		14. MOTHER'S MAIDEN NAME: <u>Annie Himmelfarb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Recd. of Spring Grove State Hosp.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<u>4201</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO Antecedent cause(s) (b) <u>Arteriosclerotic cardiovascular disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Mental illness</u>		
18a. DATE OF OPERATION: <u>10/10/55</u>		18b. MAJOR FINDING OF OPERATION:
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town, (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>	21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Dr. M. K. Kiffin</u> 1010 Lead an		
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-20-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>10-22-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Rosedale</u>
LOCATION (City, town, or county): <u>Baltimore</u>	STATE: <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>5/21/55</u>	REGISTRAR'S SIGNATURE: <u>T. E. Barry</u>	24. FUNERAL DIRECTOR: <u>Jack Lewis</u>
		ADDRESS: <u>2100 Eutan Pl</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 20 1935

RECEIVED

4417

CERTIFICATE OF DEATH

Reg. Dist. No.

04395

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
(City (if outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) TOWN Garrison 6455)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN Garrison

STREET ADDRESS (If rural give location)

3. NAME OF
DECEASED:(First) Howard (Middle) E (Last) Jackson

(Type or Print)

4. DATE
OF
DEATH (Month) May (Day) 3 (Year) 1955

5. SEX:

6. COLOR OR
RACE W7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): Single

8. DATE OF BIRTH:

9. AGE last birthday: (If under 1 year) 85 yrs. Months 0 Days 0 Hours 0 Min.10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired Retired Teacher High School10b. KIND OF BUSINESS OR
INDUSTRY MD

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY USA

13. FATHER'S NAME

Elisha Jackson

14. MOTHER'S MAIDEN NAME:

Elizabeth Price15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) No (If Yes, give year or dates of
service) No

16. SOCIAL SECURITY No

17. INFORMANT & ADDRESS

Mrs. Lucie Pittenger Garrison MD

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

456.1
Immediate cause(a) Decompensation of HeartAntecedent causes (s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.(b) Chs. Vasc. Heart Disease
(c) Cardio Vascular DiseaseInterval Between
Onset And Death2 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death Diabetes

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from

1955, to 5/2/1955, that I last saw the deceased

alive on 5/2/1955, and that death occurred at 7 PM

from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

State

DATE RECD BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/4/55 Danny B. Elmer5/3/55 Chas. C. Spton Hampstead MD

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

1. 1000
2. 1000
3. 1000
4. 1000
5. 1000
6. 1000
7. 1000
8. 1000
9. 1000
10. 1000

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4418

04396

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY 1	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rossville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rossville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 153 Lenning Lane		STREET ADDRESS (If rural, give location) 153 Lenning Lane	
3. NAME OF DECEASED (Type or Print) GEORGE LEE JEFFERSON, SR.		4. DATE OF DEATH (Month) May (Day) 13 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH March 17, 1871
9. AGE (last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Jefferson		14. MOTHER'S MAIDEN NAME same	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Mr. Howard L. Jefferson		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Arteriosclerotic Heart Disease		2 years	
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		1 month	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT SUICIDE HOMICIDE (Specify)		21. PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from March , 19 55 , to May , 19 55 , that I last saw the deceased alive on May 12 , 19 55 , and that death occurred at 4:35 a.m. , from the causes and on the date stated above.	
SIGNATURE Howard L. Jefferson		ADDRESS 8019 Philadelphia Road Baltimore 6, Md.	
DATE SIGNED May 13, 1955			
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE May 16, 1955	
NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. 5-16-55		REGISTRAR'S SIGNATURE G. W. Hedrick	
24. FUNERAL DIRECTOR H. SANDER & SONS, INC.		ADDRESS Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

04397

4333

-- CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

Item 7. Film G182 6-G-55 et

1. PLACE OF DEATH COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2510 YORKWAY		STREET ADDRESS 2510 YORKWAY	
3. NAME OF DECEASED (Type of Print)	(First) OLUF (Middle) W.M.I. (Last) JENSEN	4. DATE OF DEATH (Month) 5 (Day) 28 (Year) 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH 5-4-181
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red.) GRADER		10b. Kind of BUSINESS or Industry GRADER	
11. BIRTHPLACE (State or foreign country) DENMARK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PAUL JENSEN		14. MOTHER'S MAIDEN NAME SILIA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY No. 212 30 274	
17. INFORMANT MINI JENSEN - WIDOW			

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		
II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		

22 I certify that I took charge of the remains described above, held an Autopsy ☐. Inspect on ☒ Inquiry ☒ thereon and from the evidence obtained by and Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE **William M Kelly** (Degree or title) ADDRESS **2510 YORKWAY** DATE SIGNED **5/28/55**

23. BURIAL, CREMATION, REBURY, SPOKE	DATE THEREOF 5-30-55	NAME OF CEMETERY OR CREMATORY WILKINSON	LOCATION (City, town, or county) (State) BALTO. CO., MD.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE May 28-1955 William M Kelly		24. FUNERAL DIRECTOR William M Kelly	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 A 23

4419

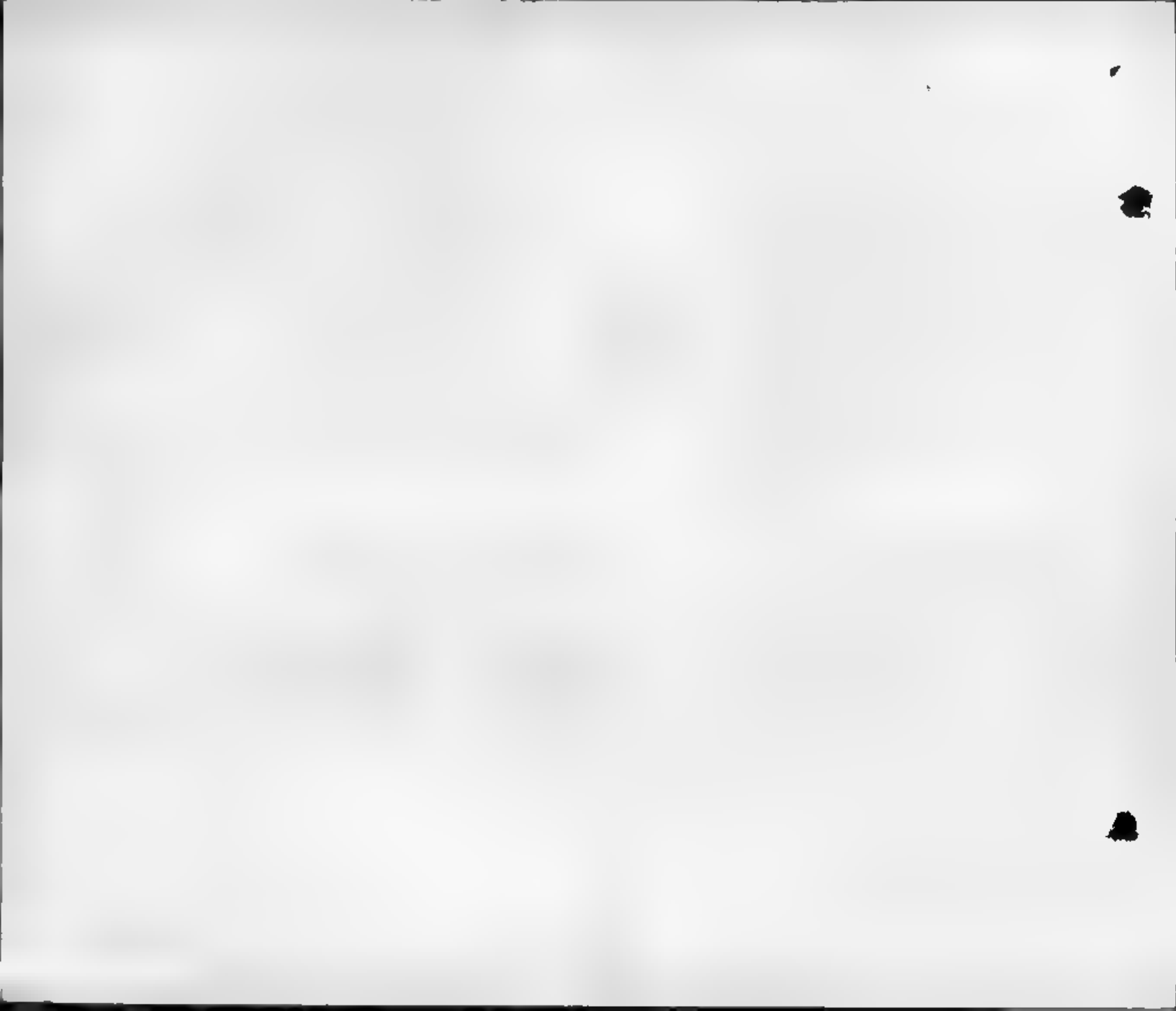
CERTIFICATE OF DEATH

Reg. Dist. No. -

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN FORT HOWARD</u> LENGTH OF STAY (in this place) <u>1 Day</u>				CITY (If outside corporate limits write RURAL, and give nearest town) <u>OR TOWN BALTIMORE</u> <u>4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1642 NATURO ROAD</u>			
3 NAME OF DECEASED: (First) (Middle) (Last) <u>ADAM H. JOHNSON</u>				4 DATE (Month) (Day) (Year) OF DEATH <u>MAY 22 1955</u>			
5 SEX <u>MALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 SINGLE MARRIED WIDOWED DIVORCED <u>MARRIED</u> 8 DATE OF BIRTH <u>9/13/93</u>				9 AGE last birthday <u>61</u> YEARS MONTHS DAYS HOURS MIN <u>61</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u>			
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u> 10B KIND OF BUSINESS OR INDUSTRY <u>APARTMENT HOUSE</u>				11 BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>			
13 FATHER'S NAME <u>ADAM JOHNSON</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14 MOTHER'S MAIDEN NAME <u>MATILDA DONALDSON</u>				15 SOCIAL SECURITY NO. <u>212 07 5288</u>			
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If Yes, give war or dates of service <u>YES</u> <u>WW-I</u>				17 INFORMANT'S ADDRESS <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>			
18 MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				1 Min.			
IMMEDIATE CAUSE (A) <u>420.1</u> <u>CORONARY INSUFFICIENCY, ACUTE</u>				UNKNOWN			
ANTECEDENT CAUSE (B) <u>DUE TO ARTERIOSCLEROSIS, GENERALIZED</u>							
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C) <u>HYPERTENSIVE VASCULAR DISEASE</u>				5 Years			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>ANEURISM, AORTA, ABDOMINAL</u>				Unknown			
12A DATE OF OPERATION 12B MAJOR FINDINGS OF OPERATION				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21B PLACE (Home, farm, factory, street, office bldg., etc.) INJURY OCCURRED			
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>				21E INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>			
21F HOW DID INJURY OCCUR?							
22 I hereby certify that I attended the deceased from <u>MAY 21, 1955</u> , to <u>MAY 22, 1955</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>GEORGE LERNER, M.D.</u> M.D. <u>VAH, FORT HOWARD, MD.</u>				DATE SIGNED <u>5/22/55</u>			
23 BURIAL CREMATION (REMOVAL) (Specify) <u>BURIAL</u> DATE THEREOF <u>5/25/55</u> NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u> LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>							
DATE REC'D BY LOCAL REGISTRAR <u>5/28/55</u> REGISTRAR'S SIGNATURE <u>G. A. Hedrich</u>				24 FUNERAL DIRECTOR <u>WM-COOK-BLIGHT FUNERAL HOME</u> ADDRESS <u>6009 HARFORD Rd. BALTIMORE, MD.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4420

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1 PLACE OF DEATH

COUNTY **BALTIMORE**CITY If outside corporate limits write RURAL LENGTH OF STAY
OR a d e nearest town in this placeTOWN **FORT HOWARD****29 DAYS**HOSPITAL OR
INSTITUTION OR
STREET ADDRESS**VETERANS ADMINISTRATION HOSPITAL**

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE **MARYLAND**

COUNTY

CITY If outside corporate limits write RURAL and give nearest town)

OR
TOWN **BALTIMORE**

STREET ADDRESS If rural give location)

4216 EVANS CHAPEL ROAD3 NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

RUSSELL**C****JOHNSON**

5 SEX

6

MALE

7

COLORED

8

MARRIED

9

5/25/90

4

DATE Month (Day (Year

OF

DEATH **MAY 8**

1955

AGE and birthday) UNDER 1 YEAR UNDER 1 MRS. Months Days Hours Min.

64 yrs

10A USUAL OCCUPATION (five kind of work done during most of working life even if retired)

FIREMAN

10B KIND OF BUSINESS OR INDUSTRY

HOSPITAL

11 BIRTH-PLACE (State or foreign country)

REISTERSTOWN, MARYLAND

12 CITIZEN OF WHAT COUNTRY?

U.S.A.

13 FATHER'S NAME

WILLIAM JOHNSON**SARAH HUGHES**

14 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. If Yes give war or dates of service)

YES**WW-I**

15 SOCIAL SECURITY NO.

216 03 9571

17 INFORMANT'S ADDRESS

CLIN. REC. VET. ADM. HOSP., FT. HOWARD, Md.

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1**IMMEDIATE CAUSE****ANTECEDENT CAUSE (S**

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) MYOCARDIAL INFARCTION**DUE TO****HYPERTENSIVE CARDIOVASCULAR DISEASE****(B)****DUE TO****(C)**

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

ARTERIOSCLEROTIC VASCULAR DISEASE

19A DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY?

YES ☐NO ☒

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)

21B PLACE Where (farm, factory, OF INJURY street, office bldg., etc.)

21C WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D TIME (Month (Day (Year (Hour) OF INJURY

21E INJURY OCCURRED While ☐ Not while ☐ at work at work

21F HOW DID INJURY OCCUR?

22 I hereby certify that I attended the deceased from **April 9, 1955** to **May 8, 1955**, the death occurred at **5:55A M.** from the causes and on the date stated above**SIGNATURE****ADDRESS****DATE SIGNED****IRVING FREEMAN, M.D.****M D****VAH, FORT HOWARD, MD.****5/8/55**

23 BURIAL CREMATION REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION City town or county

State

BURIAL**MAY 12 1955****St. LUKE'S CEMETERY****REISTERSTOWN, Md.**

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

GEORGE H. HOLLAND FUNERAL HOME**1631 DRUID HILL AVE. BALTO, MD.**

MARGIN RESERVED FOR BINDING

VS. A15-10-52

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4421

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND <u>MD</u> CITY (if inside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> LENGTH OF STAY (in this place) <u>17 Months</u> TOWN <u>Cockeysville</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Balt</u> CITY (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS (if rural give location) <u>506 B. St. Sparrow Point</u>	
3 NAME OF DECEASED (Type or Print) <u>Gertrude Leonard Jones</u> First: <u>Gertrude</u> Middle: <u>Leonard</u> Last: <u>Jones</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>May 16 1955</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE MARRIED WIDOWED DIVORCED (Specify) <u>Widow</u>	8 DATE OF BIRTH <u>Nov. 10-1877</u> - <u>77</u> yrs. <u>6</u> months <u>1</u> day <u>1</u> min.
9A USUAL OCCUPATION Give kind of work done during most of working life even if retired <u>Housework</u>		9B KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	10 BIRTHPLACE (State or foreign country) <u>Chicago</u>
11 FATHER'S NAME <u>Thomas Leonard</u>		12 MOTHER'S MAIDEN NAME <u>Mary</u>	
13 IF WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk. If Yes, give war or dates of service) <u>None</u>		14 SOCIAL SECURITY NO. <u>None</u>	
15 MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>931X</u> IMMEDIATE CAUSE (A) <u>Cerebral Vascular accident</u> ANTECEDENT CAUSE (B) <u>Generalized & Cerebral arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Generalized & Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Several years</u>	
16 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
17A DATE OF OPERATION <u>0</u>		17B MAJOR FINDINGS OF OPERATION	
18A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		18B PLACE (Home, farm, factory or INJURY street, office bldg., etc)	
19A TIME (Month) (Day) (Year) (Hour) OF INJURY		19B INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20 I hereby certify that I attended the deceased from <u>Dec. 1953</u> to <u>May 16, 1955</u> that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.		21 WHERE DID INJURY OCCUR? (City or town) (County) (State)	
SIGNATURE <u>Walter T. Lees</u>		DATE SIGNED <u>17 May 1955</u>	
22 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>May 18-55</u>		23 NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> LOCATION (City town or county) (State) <u>Baltimore MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 19 1955</u>		24 FUNERAL DIRECTOR <u>St Paul & Preson St</u>	

MARGIN RESERVED FOR BINDING

BUTLER

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04401

MARYLAND

STATE DEPARTMENT OF HEALTH

4422

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Owings Mills LENGTH OF STAY (In this place) 12 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Owings Mills	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Park Heights Ave.		STREET ADDRESS (If rural, give location) Park Heights Ave.	
3. NAME OF DECEASED (Type or Print) (First) Samuel (Middle) G (Last) Kelley		4. DATE OF DEATH (Month) May (Day) 14 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 13, 1908
9. AGE last birthday 47 yrs.		10. AGE last birthday (If under 1 year 1 month 1 day 1 hour 1 min.)	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Employed at Hunter Wilson Distillery		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Thomas L. Kelley		14. MOTHER'S MAIDEN NAME Martha Vest	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. 215-22-4684	
17. INFORMANT AND ADDRESS Mrs. Rennis G. Kelley, Owings Mills, Md.			

18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.2 Immediate cause (a) Angina Pectoris				2 1/2 mos.	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) (b) Lumbar intervertebral disc				10 1/2 mos.	
20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
21. DATE OF OPERATION 12-25-55		22. MAJOR FINDINGS OF OPERATION Lumbar disc		23. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
24. ACCIDENT SUICIDE HOMICIDE none		PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY none		CITY OR TOWN (COUNTY) (STATE) none	
TIME (Month) (Day) (Year) (Hour) OF INJURY none		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? none	
25. I hereby certify that I attended the deceased from 11-3 , 19 40 , to 5-14 , 19 55 , that I last saw the deceased alive on 5-14-55 , 19 55 , and that death occurred at 4:30A. m., from the causes and on the date stated above.					
SIGNATURE D. S. Caples		ADDRESS 6 Hanover Rd., Reisterstown, Md.		DATE SIGNED 5-19-55	
26. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE May 17, 1955		NAME OF CEMETERY OR CREMATORY Dover Cemetery	
DATE REC'D BY LOCAL REG. 5-16-55		REGISTRAR'S SIGNATURE Mary B. Eline		27. FUNERAL DIRECTOR ADDRESS J.F. Eline & Sons, Reisterstown, Md.	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

1894

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

4423

1 PLACE OF DEATH

COUNTY Balto. MARYLAND
 CITY If outside corporate limits write RURAL LENGTH OF STAY
 OR a d s nearest town (In this place)
 X TOWN Lothearn
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS 3617 Patterson Ave.

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY Balto.
 CITY If outside corporate limits write RURAL and give nearest town
 OR
 TOWN Lothearn
 STREET ADDRESS (If rural give location)
3617 Patterson Ave.

3 NAME OF DECEASED
(Type or Print)

First (Middle) (Last)
PETER JOSEPH Kelly, Jr.

4 DATE (Month) (Day) (Year)
OF DEATH

May 31, 1955

5 SEX

6 COLOR OR RACE

7 SINGLE MARRIED

8 DATE OF BIRTH

9 AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

male white single Sept. 17, 1919 5 yrs. Months Days Hours Min.

10A USUAL OCCUPATION (give kind of work done during most of working life, even if retired):

10B KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country)

12 CITIZEN OF WHAT COUNTRY:

13 FATHER'S NAME

14 MOTHER'S MAIDEN NAME

Peter Joseph Kelly, Sr.

M. Elizabeth Slenaker

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service:

16 SOCIAL SECURITY NO.

17 INFORMANT'S ADDRESS

Mr. P. J. Kelly, Sr. - 3617 Patterson Ave.

18. MEDICAL CERTIFICATION

A DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

587.2

IMMEDIATE CAUSE

(A) DUE TO

Heart Failure

ANTECEDENT CAUSE (B)

(B) DUE TO

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

Cystic Fibrosis of PANCREAS

(C) DUE TO

BRONCHIECTASIS + PNEUMONIA

INTERVAL BETWEEN ONSET AND DEATH

1 month

since birth

2 yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A DATE OF OPERATION 19B MAJOR FINDINGS OF OPERATION

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MED. EXAM. NER)

21B PLACE (Home, farm, factory, street, office bldg., etc.)

21C WHERE D.D. INJURY OCCURRED (City or town) (County) (State)

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED While at work Not while at work

21F HOW DID INJURY OCCUR?

20 AUTOPSY? YES ☐ NO ☒

22. I hereby certify that I attended the deceased from Sept 18, 1949 to May 31, 1955, that I last saw the deceased alive on May 31, 1955, and that death occurred at 7 P. M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23 BURIAL CREMATION, DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City or county) (State)

Burial

6/3/55

holy Redeemer Can.

Balto., Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

6-2-55

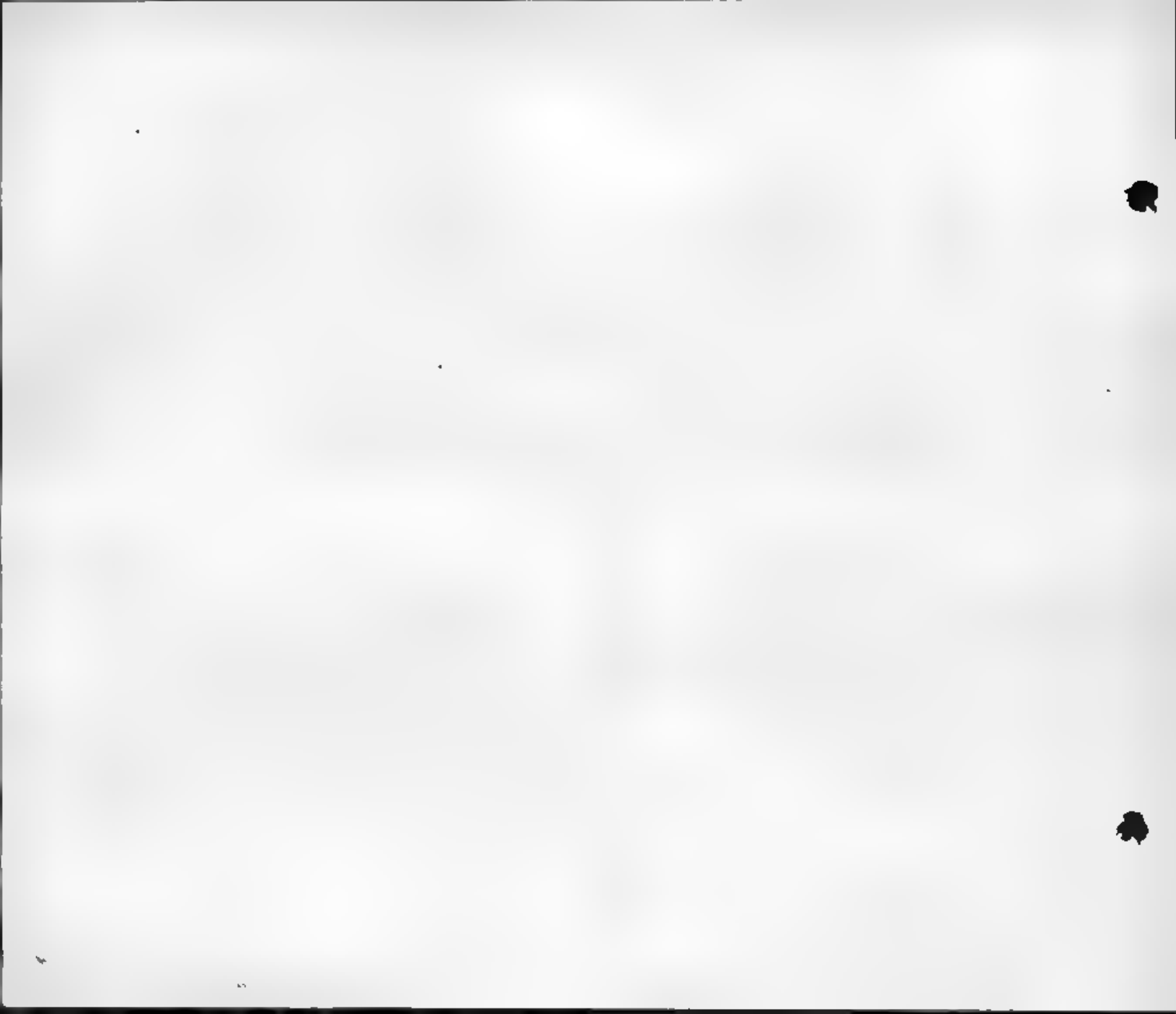
W. H. H. H.

Wm. J. H. H.

17

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4424

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04403

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middleboro</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middleboro</u>		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>209 Helena Rd.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>OTTO</u> (Middle) <u>J.</u> (Last) <u>KLEMPSTEIN</u>				DATE (Month) (Day) (Year) <u>5-11-1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married Aug 19-1891</u>	8. DATE OF BIRTH:	9. AGE last birthday: <u>63</u> yrs.	10. AGE last birthday: 71 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, if relevant) <u>Electrician</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>Crown-Lock Co</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>JOSEPH V. Klemstein</u>				14. MOTHER'S MAIDEN NAME: <u>Rosalie M. Surrency</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS: <u>Minnie Klemstein (Same)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO							
Antecedent cause(s) (b) <u>Coronary artery disease</u> DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION. 19b. MAJOR FINDINGS OF OPERATION:							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		CITY OR TOWN		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 23, 1953</u> to <u>Apr 12, 1955</u> , that I last saw the deceased alive on <u>Apr 12, 1955</u> , and that death occurred at <u>8:50 P.M.</u> from the causes and on the date stated above							
SIGNATURE <u>Joseph Frank</u> (DEGREE OR TITLE) ADDRESS <u>423 Eastern Ave Balto Md</u>				DATE SIGNED <u>5/13/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowdale Cemetery</u>		LOCATION (City, town or county) (State) <u>Balto. Md</u>	
DATE REC'D BY LOCAL REG. <u>5/14/55</u>		REGISTRAR'S SIGNATURE <u>G. A. H. Newley</u>		24. GENERAL DIRECTOR <u>John J. Connelly</u>		ADDRESS <u>Essex, Md</u>	

U. S. V. S.

1871

4334

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

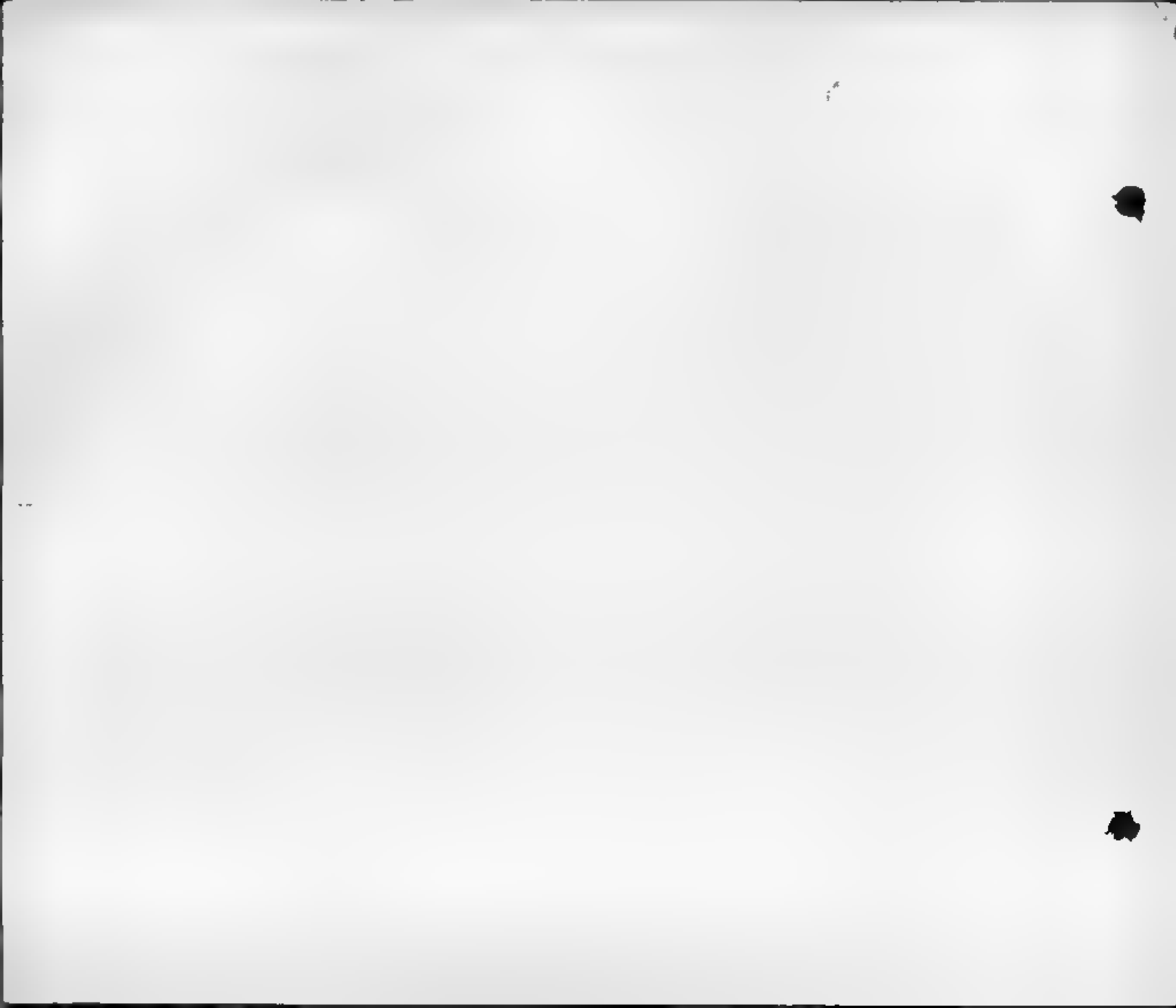
Reg. Dist. No.

41

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk		CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1923 Merritt Avenue		STREET ADDRESS 1923 Merritt Avenue	
3. NAME OF DECEASED (Type or Print) MINNIE (First) KONOPKA (Last)		4. DATE OF DEATH Month May Day 27 Year 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. Widowed	8. DATE OF BIRTH Aug. 20, 1889
9. AGE last birthday 65 yrs.		10. BIRTHPLACE (State or foreign country) Warsaw, Poland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Abramowski		14. MOTHER'S MAIDEN NAME Juliana Olko	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No. 214-03-3163	
17. INFORMANT Mrs. Ruth Martino -1743 Portship Rd		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Coronary Occ. cause			
Antecedent cause(s) (b) Hyperplastic Cardiac Vascular System			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by and Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE W. J. Davis		DATE SIGNED 5/27/55	
23. BURIAL, CREMATION, REINTERMENT (Specify) Burial		DATE THEREOF May 30, 1955	
NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		LOCATION (City, town, or county) (State) Dundalk, Maryland	
24. FUNERAL DIRECTOR H. SANDER & SONS, INC.		ADDRESS Baltimore, Maryland	

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician please write the causes of death clearly and legibly.

1 PLACE OF DEATH. COUNTY BALTO MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) TOWN SPARROWS POINT 3 DARS
1 STREET ADDRESS CARROLL NURSING HOME
3 NAME OF DECEASED: (First) FRANK (Middle) H. (Last) LIDSTON
5 SEX M. 6 COLOR OR RACE W. 7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED 8 DATE OF BIRTH 1-21-1866
9 AGE last birthday 88 yrs. 10 DATE OF DEATH 5-2-55
11 BIRTHPLACE (State or foreign country) SWEDEN 12 CITIZEN OF WHAT COUNTRY? SWEDEN
13 FATHER'S NAME: UNKNOWN 14 MOTHER'S MAIDEN NAME: UNKNOWN
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO 16 SOCIAL SECURITY No. 012-16-5575 17 INFORMANT & ADDRESS: E. J. LIDSTON- 118 VENTNOR TERRACE DUNDALK 22, Md.

18 MEDICAL CERTIFICATION
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
4-5-55 Immediate cause (a) Anterior infarct Cardio Vascular
DUE TO
Antecedent cause(s) (b) disease
DUE TO (c) Senility
Interval Between Onset And Death 1 day

11 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
19a DATE OF OPERATION 19b MAJOR FINDINGS OF OPERATION
20 AUTOPSY? Yes ☐ No ☒
21 ACCIDENT (Specify) SLIP, TRIP, FALL PLACE (Home, farm, factory, street, office bldg, etc.) INJURY OCCURRED (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While at Work ☐ HOW DID INJURY OCCUR?

22 I hereby certify that I attended the deceased from May 1, 1955, to May 2, 1955, that I last saw the deceased alive on May 1, 1955, and that death occurred at 9:00-1 P.M. from the causes and on the date stated above.
SIGNATURE M. Spawr M.D. (Degree or title) DATE SIGNED 5/4/55
23 BURIAL (CREMATION, REMOVAL) (Specify) DATE THEREOF 5-5-1955 NAME OF CEMETERY OR CREMATORY WOODSON PARK LOCATION (City town or county) (State) BALTO. MD.
DATE REC'D BY LOCAL REGISTRAR May 4-55 REGISTRAR'S SIGNATURE L. Barber 24 FUNERAL DIRECTOR ADDRESS 2414 Park Heights, Dundalk 22, Md.

MARGIN RESERVED FOR BINDING

DOUGLAS V. S.

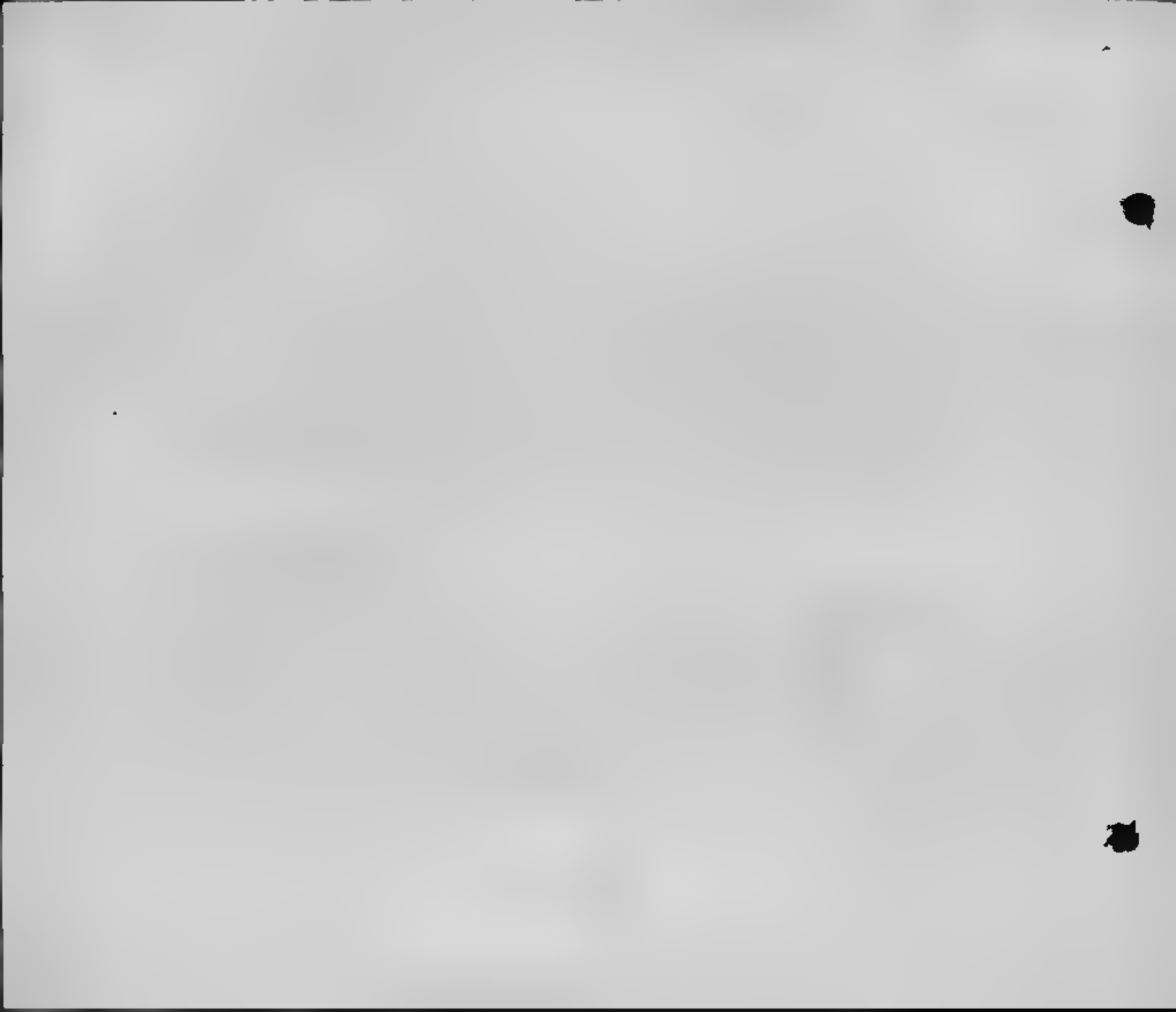
1911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

4426 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04406 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Balto</u>	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (If this time)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Essey, Balto</u>	<u>5 yrs.</u>	TOWN <u>Bome</u>	<u>54</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>801 Brunswick Rd</u>	STREET ADDRESS (If rural, give location) <u>1</u>		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month, Day, Year)	
<u>Clustering Hagen Lunsford</u>		<u>May 8 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct 13/1880</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION Give kind of work done during most of work life, even if retired: <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>North Carolina</u>	
11. FATHER'S NAME: <u>Raurence Hagen</u>		12. CITIZEN OF WHAT COUNTRY?	
13. MOTHER'S MAIDEN NAME: <u>Rachel Randall</u>		14. INFORMANT & ADDRESS: <u>Mrs. Sarah Goforth (Daughter)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>Immediate</u>	
17a. Immediate cause (a) DUE TO <u>Coronary occlusion</u>			
17b. Antecedent cause(s) (b) DUE TO <u>Carcinomatosis general</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		<u>Carcinoma of Thyroid</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
18a. DATE OF OPERATION: <u>11</u>		18b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)	
21c. (City or town):		(County)	
21d. TIME (Month) (Day) (Year) (Hour) <u>May 8 - 5:15 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>M. D.</u>		DATE SIGNED: <u>May 9, 1955</u>	
23. BY NAME, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>REMOVAL</u>		<u>MAY 9, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>MACE DONIA CEM.</u>		<u>ASHEVILLE, N. CAR.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Wm. Cook Wright, Sr.</u>		<u>6009 HARFORD Rd.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

Item 2. Film 6182 C-6-65 of

1. PLACE OF DEATH

COUNTY BALTO. MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)
 TOWN CATONSVILLE
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 FUSTING AVE

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTO 31014
 STREET ADDRESS (If rural give location) 528 TUNBRIDGE RD

3. NAME OF DECEASED (Type or Print)

First (Middle) (Last)
GEORGE W LYNCH

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED

WIDOWER

8. DATE OF BIRTH

8-12-83

9. AGE last birthday

71

10. DATE OF DEATH

MAY 31 1955

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

Postal Worker U.S. Govt.

13. FATHER'S NAME

WILLIAMS LYNCH

14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

15. SOCIAL SECURITY No.

16. INFORMANT'S ADDRESS

KENNETH LYNCH

17. MOTHER'S MAIDEN NAME

SARA H. MCNEAL

18. CITIZEN OF WHAT COUNTRY?

U.S.A.

19. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause
114 x 114

(a)

DUE TO

Antecedent causes (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

Specify

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work

Not While At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-18, 1952, to 5-31, 1955, that I last saw the deceased

alive on 5-31, 1955, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William K. Gallagher M.D. 6209 Frederick Rd. Balt. 28, Md. 5-31-55

23. BURIAL (CREMATION, REMOVAL) (Specify)

BURIAL

DATE THEREOF

16-2-1955

NAME OF CEMETERY OR CREMATORY

PARKWOOD

LOCATION (City, town, or county)

BALTO Co

(State)

MD

DATE REC'D BY LOCAL REGISTRAR 6-1-55

REGISTRAR'S SIGNATURE H. W. Jenkins

24. FUNERAL DIRECTOR H.W. JENKINS & SONS Co.

ADDRESS

4905 YORK RD. BALTO. 12, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04408

4335

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>131 N. Avenue K</u>		STREET ADDRESS (If rural, give location) <u>731 N. Avenue K</u>	
3. NAME OF DECEASED (Type or Print) <u>Ed</u> (First) <u>Green</u> (Middle) <u>Marion</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 18, 1894</u>
9. AGE last birthday <u>61</u> yrs. If under 1 year: Months <u>2</u> Days <u>4</u> Hours <u>1</u> Min. <u>5</u>		10. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Ed Green</u>		14. MOTHER'S MAIDEN NAME <u>Acasa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>213-01-5914</u>	
17. INFORMANT AND ADDRESS <u>Lizette Marion 731 N. Avenue K</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Uremia</u>		<u>2 days</u>	
(b) Antecedent cause(s) <u>Pneumonia, Hypostatic</u>		<u>30 days</u>	
(c) <u>Arthritis</u>		<u>3 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) - (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at - Not While Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 30, 1954</u> to <u>May 17, 1955</u> , that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>9 PM</u> m., from the causes and on the date stated above.			
SIGNATURE <u>St. Lynn E. Smith, M.D.</u>		DATE SIGNED <u>May 17, 1955</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore City Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5/20/55</u>		REGISTRAR'S SIGNATURE <u>Charles A. Law</u> ADDRESS <u>802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4428

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

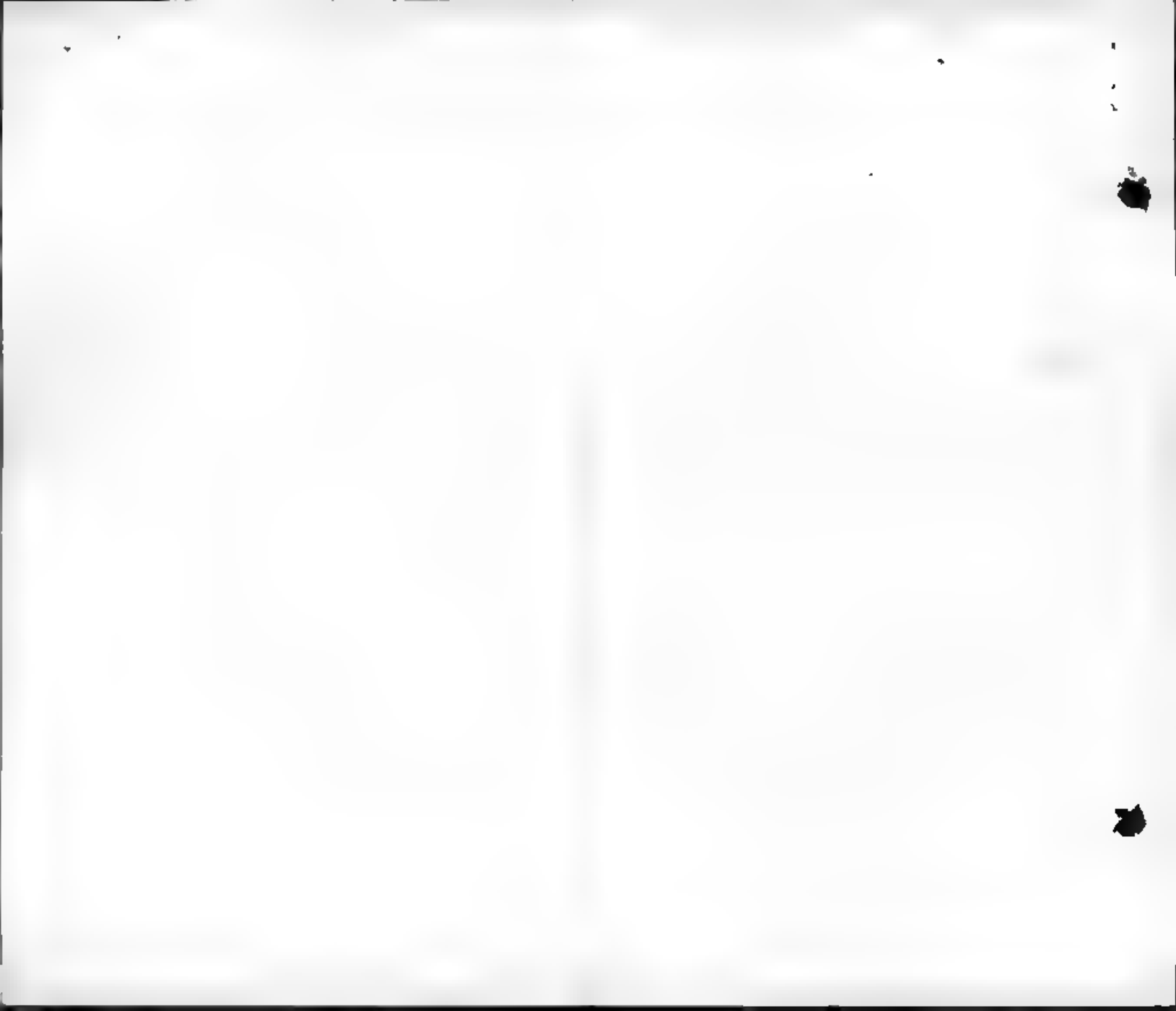
04409

Item 18, By Phone: Dr. Newcomer 5/4/55

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH Baltimore COUNTY MARYLAND CITY If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town (if this place) TOWN Mt Wilson Md. 15 Days HOSPITAL OR INSTITUTION OR STREET ADDRESS 02 Mt Wilson State Hospital		2 USUAL RESIDENCE HOME OF DECEASED Maryland STATE COUNTY Prince George CITY If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville 16 1 STREET ADDRESS (if rural give location) 2720 Kirkwood Place	
3 NAME OF DECEASED (Type or Print) Benjamin First (Middle) (Last) 5 SEX Male 6 COLOR OR 7 SINGLE MARRIED RACE White 8 DATE OF BIRTH 3-7-1888 WIDOWED DIVORCED, (Specify)		4. DATE (Month) (Day) (Year) OF DEATH May 3 1955 9 AGE last birthday 67 yrs. 10A UNDER 1 YEAR IF UNDER 18 MRS. Months Days Hours Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B KIND OF BUSINESS OR INDUSTRY Barber		11 BIRTHPLACE (State or foreign country) Italy 12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Nicholas Marchione 14 MOTHER'S MAIDEN NAME Eleanor Catuti		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 2 Year WWI 16 SOCIAL SECURITY NO. ? 17. INFORMANT & ADDRESS Hospital Records	
18 MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH OIOX IMMEDIATE CAUSE ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (A) 1 Meningitis, acute tubercular DUE TO (B) 2 Pneumonitis, acute, diffuse DUE TO (C) 3 Nephritis, chronic		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Pulmonary tuberculosis			
19A DATE OF OPERATION 2 19B MAJOR FINDINGS OF OPERATION		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 21B PLACE (Home, farm, factory, etc.) 21C WHERE DID INJURY OCCUR? (City or town) (County) (State) 21D TIME (Month) (Day) (Year) (Hour) OF INJURY 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4 29, 19 54 to 5 3, 19 55, that I last saw the deceased alive on 5 3, 19 55, and that death occurred at 12 45 AM, from the causes and on the date stated above. SIGNATURE William Newcomer ADDRESS M D Mt Wilson MD DATE SIGNED 5-3-55			
23 BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF 5-5-55 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington VA State)			
DATE REC'D BY LOCAL REGISTRAR 5/5/55 REGISTRAR'S SIGNATURE Amanda L. [Signature]		24 FUNERAL DIRECTOR [Signature] ADDRESS 3831 Palmer St.	



4429

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1 PLACE OF DEATH

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Woodlawn LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS
2008 Hillcrest Avenue

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Woodlawn, Maryland
 STREET ADDRESS (If rural, give location)
2008 Hillcrest Avenue

3 NAME OF DECEASED (Type or Print)

(First)

(Middle)

(Last)

George Martin

4 DATE OF DEATH

(Day)

(Year)

May 5,19 55

5 SEX

6 COLOR OR RACE

7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8 DATE OF BIRTH

9 AGE last birthday

IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.

MaleWhiteMarriedNovember 27, 187579 yrs

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country)

12 CITIZEN OF WHAT COUNTRY?

ClerkB&O RailroadIrelandU.S.

13 FATHER'S NAME

Allan MartinEsther McCully

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT & ADDRESS

Addie P. Martin 2008 Hillcrest Avenue

18 MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
422.1
IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (B)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH
Sanility

19A DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY?

YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory or INJURY street, office bldg., etc)

21C WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

M

21E INJURY OCCURRED While at work Not while at work

21F HOW DID INJURY OCCUR?

22 I hereby certify that I attended the deceased from Sept 16, 1951, to May 5, 1955, that I last saw the deceasedalive on May 4, 1955, and that death occurred at 6 P. M., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23 BURIAL CREMATION REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City or town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

BurialMay 9, 1955LorraineBaltimore, Maryland5-6-55A. W. HensworthEdith Hensworth4600 Liberty Heights Avenue

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.



4336

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04411

Reg. Dist. No. 41

1. PLACE OF DEATH - COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO</u>	
(CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK (22)</u> LENGTH OF STAY (In this place) <u>35 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK 22</u> 53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>39 Northship Rd.</u>		STREET ADDRESS (If rural, give location) <u>39 NORTHSHIP RD.</u> 1	
3. NAME OF DECEASED (Type or Print) <u>HENRY EDGAR M^cBRIDE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-22-53</u> 19	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>3-5-1873</u>
9. AGE last birthday <u>82</u> yrs.		10. IS AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.K.</u>	
13. FATHER'S NAME <u>PETER M^cBRIDE</u>		14. MOTHER'S MAIDEN NAME <u>SUSANNAH RICHARDS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21307-044</u>	
17. INFORMANT AND ADDRESS <u>MRS. JAMES O CHILDS</u>		<u>RUSSELL KY.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

1. Immediate cause (a)

(a)

Arterio-Sclerotic Cardio Vascular Toxic

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Remedy10413

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

PLACE (Home, farm, factory, street, office, etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. RITUAL CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 24-1955 William M KellyWm. M. Kelly Dundalk, Md.

MARGIN RESERVED FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

RECEIVED

4430

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

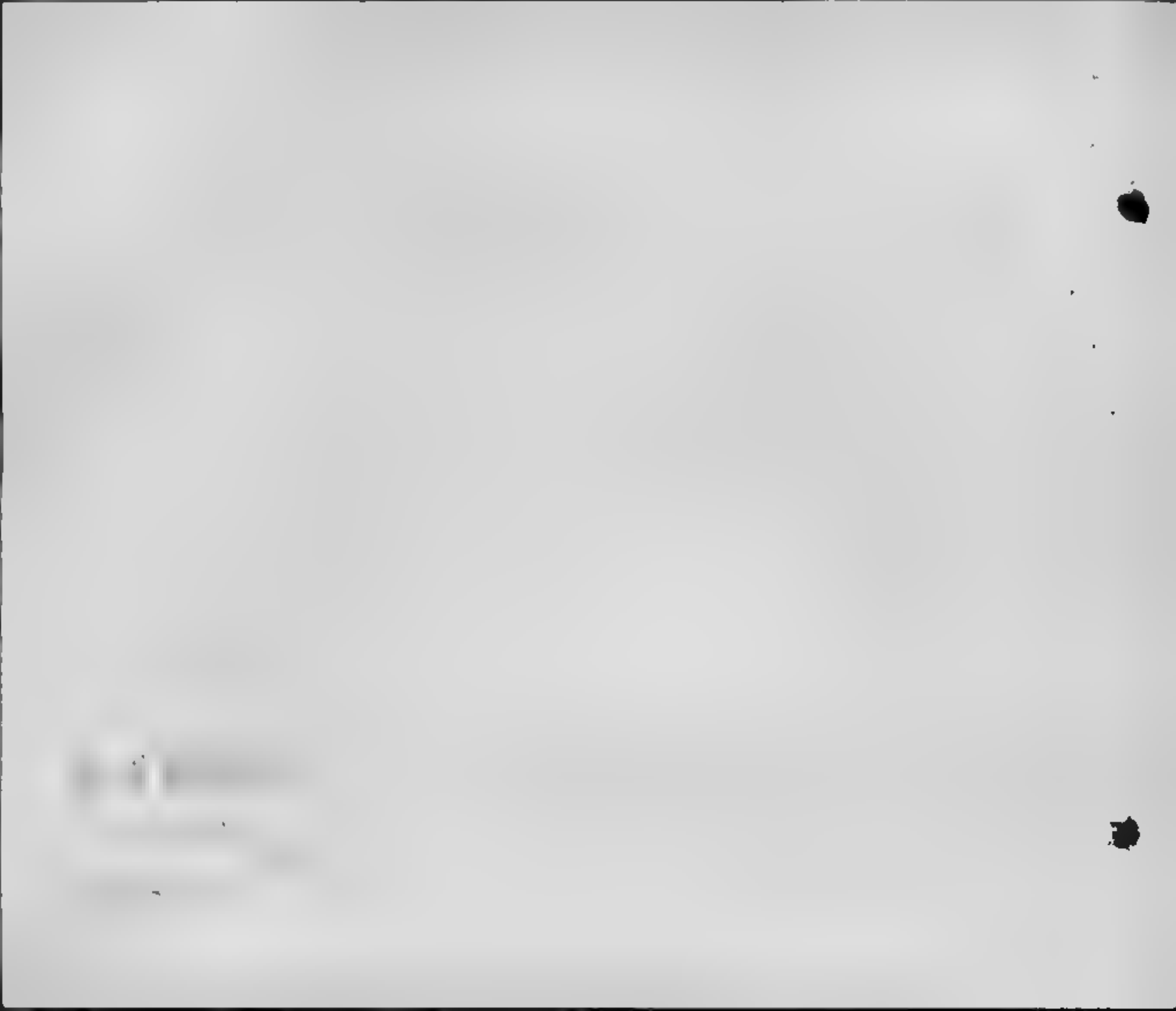
Reg. Dist. **04412**
 No. **32**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Prince George's
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN t. Wilson		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Edmonston	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wt. Wilson State Hospital		STREET ADDRESS (If rural, give location) 5111 Decatur Street	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Bell Patrick (Middle) McFarland (Last) Bell Patrick McFarland		(Month) 5 (Day) 5 (Year) 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:
Male	White	Single	12/5/03
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired).	
51 yrs		Painter	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Hyattsville, Md.		U.S.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
George M. McFarland		Catherine Fowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
Yes Army		577-18-0L39	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Hospital records			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH Approx. 1 year
Immediate cause (a) Pulmonary Tuberculosis; Far Advanced DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION.		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)
None	None	None
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
None	None	None
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE X. L. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM <input type="checkbox"/> 5-6-55
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
None	None	None
24. FUNERAL DIRECTOR	ADDRESS	
Francis Gasch's Sons	Hyattsville Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04413

4431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard P.O.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Bay Rd + Todd Ave</u>		STREET ADDRESS <u>#1</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas Wade Melton</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 7, 1919</u>
9. AGE last birthday <u>35</u> years		10. AGE last birthday <u>35</u> years	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. Kind of BUSINESS OR INDUSTRY <u>Farming</u>	
12. CITIZENSHIP OF DECEASED <u>U.S.A.</u>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Tom. W. Melton (son) as in #1</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Arteriosclerosis + Chronic Myocarditis</u>			<u>10 yrs</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Chronic asthma + pulmonary emphysema</u>			<u>10 yrs</u>
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4 yrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT (Specify)		20. PLACE (Home, farm, factory, street, OF office bldg., etc.)	
21. SUICIDE HOMICIDE		21. INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Aug 1, 1953</u> to <u>May 25, 1955</u> that I last saw the deceased alive on <u>May 19, 1955</u> and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.		23. DATE SIGNED <u>5/25/55</u>	
SIGNATURE <u>Thomas H. Gallin</u>		ADDRESS <u>M.R. 6908 North Point Rd Balto. 19</u>	
24. BURIAL, CREMATION, REMOVAL (Specify)		24. DATE THEREOF <u>May 26, 1955</u>	
25. NAME OF CEMETERY OR CREMATORY <u>Meadowdale</u>		26. LOCATION (City, town, or county) (State) <u>Howard County Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/21/55</u>		27. REGISTRAR'S SIGNATURE <u>AW Melton</u>	
28. FUNERAL DIRECTOR		29. ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4432 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04414
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Reisterstown (rural)		LENGTH OF STAY (in this place) 13 yrs.		CITY (If outside corporate limits write RURAL and give nearest town) Reisterstown (rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Butler Road				STREET ADDRESS (If rural, give location) Butler Road			
3. NAME OF DECEASED (Type or Print) Paul Eugene Merkel		4. DATE OF DEATH May 12 1955		5. SEX: Male		6. COLOR OR RACE: White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Mar. 12, 1910		9. AGE last birthday: 45 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Equip. operator Md. State Roads		11b. KIND OF BUSINESS OR INDUSTRY: Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Walter E. Merkel		14. MOTHER'S MAIDEN NAME: Ruth Zahn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give war or dates of service) no none		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS. Mrs. Margaret E. Merkel, Reisterstown, Md.		18. MEDICAL CERTIFICATION		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
Immediate cause (a) Angina Pectoris DUE TO		Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none			
21a. DATE OF OPERATION: none		21b. MAJOR FINDING OF OPERATION: none		22. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		21b. PLACE (Home, farm, factory OF street, office bldg. etc.) none		21c. (City or town) (County) (State) none			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY none M		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/> none		21f. HOW DID INJURY OCCUR? none			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM 5-16-55			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 5-15-55		NAME OF CEMTERY OR CREMATORY Jessons Methodist		LOCATION (City town or county) (State) Sparks, Md.	
DATE REC'D BY LOCAL REG. 5-15-55		REGISTRAR'S SIGNATURE Mary B. Zing		24. FUNERAL DIRECTOR Brooks Funeral Service, Sparks, Md.		ADDRESS	

1940

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

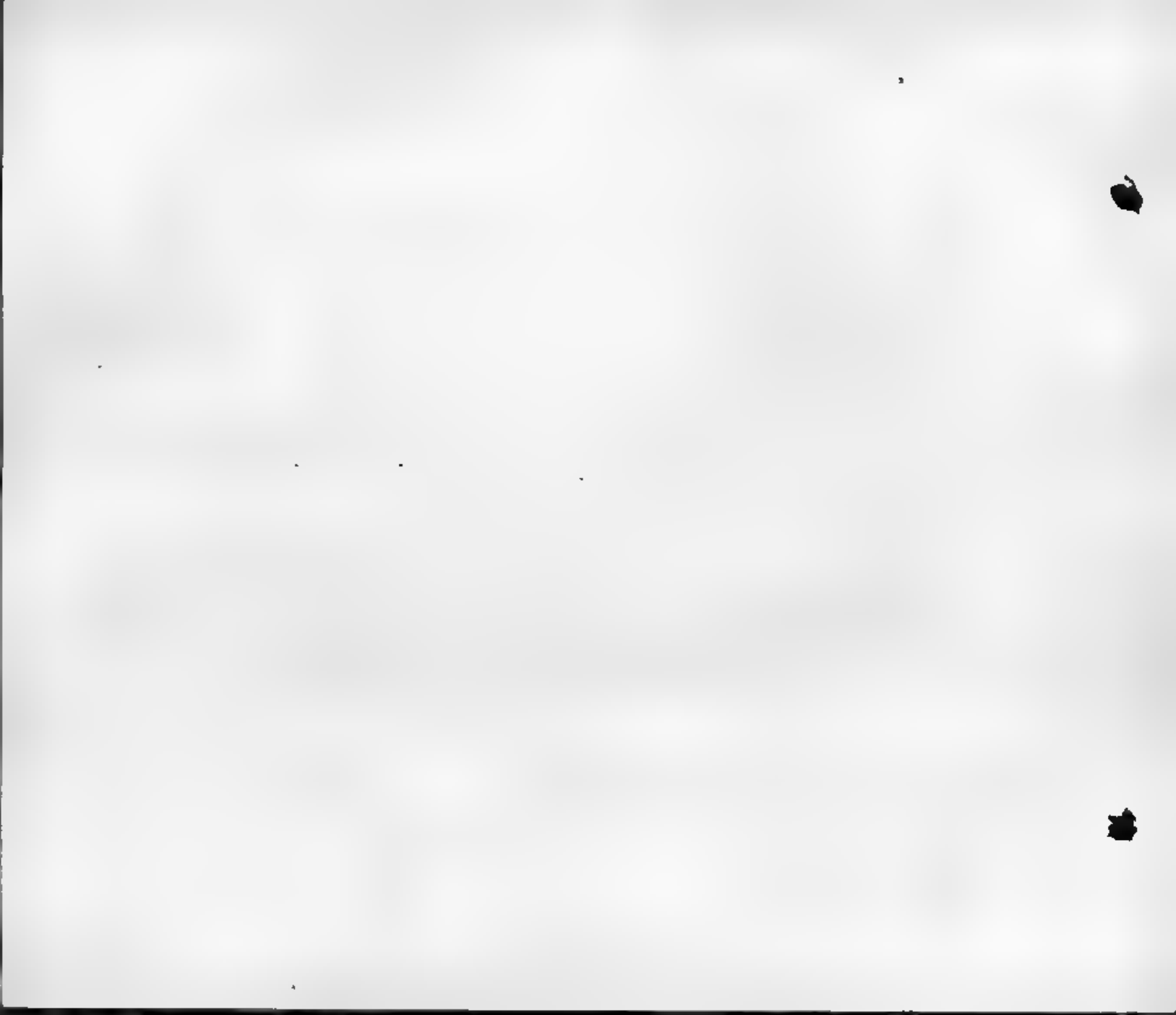
4433

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 044154

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY BALTIMORE CITY FORT HOWARD OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL	MARYLAND LENGTH OF STAY 3 DAYS	STATE MARYLAND CITY BALTIMORE OR TOWN STREET ADDRESS 1331 BRUNT STREET	COUNTY (If rural give location) 31.4
3 NAME OF DECEASED (Type or Print) WILLIAM H. MICKEY		4 DATE OF DEATH MAY 5 1955	
5 SEX MALE	6 CO OR OR 7 SINGLE MARRIED COLORED MARRIED	8 DATE OF BIRTH 12-19-24	9 AGE last birthday 30 yrs Months Days Hours Min.
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) JANITOR		10B KIND OF BUSINESS OR INDUSTRY PRIVATE CONCERN	
11 BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13 FATHER'S NAME ERNEST MICKEY		14 MOTHER'S MAREN NAME AMY CROMWELL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16 SOCIAL SECURITY NO 220-14-8197	
17 INFORMANT'S ADDRESS CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN	
54 0 IMMEDIATE CAUSE (A) FATTY LIVER WITH CIRRHOSIS; JAUNDICE.			
ANTECEDENT CAUSE (B) ACUTE GASTRIC ULCER WITH MODERATE HEMORRHAGE		UNKNOWN	
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
18A DATE OF OPERATION 2		18B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B PLACE (Home farm factory street office bldg etc) OF INJURY	
21C WHERE D.D. INJURY OCCURRED City or town (County) (State)			
21D TIME (Month (Day) Year) Hour) OF INJURY VA M		21E INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAY 2, 1955 , to MAY 5, 1955 and that death occurred at 1:40 M. from the causes and on the date stated above			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		DATE SIGNED 5-6-55	
23 BURIAL CREMATION DATE THEREOF BURIAL 5-8-55		NAME OF CEMETERY OR CREMATORY LOCATION (City or town or county) ARBUTUS MEMORIAL PARK CEMETERY BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR May 7 1955		24 FUNERAL DIRECTOR Arlington S. Phillips, 1808 N. Monroe St. Baltimore 17, Md.	



4434

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rural</u> <u>Randallstown</u> TOWN <u>Rural</u> <u>Randallstown</u> X HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Holbrook</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rural</u> <u>Randallstown</u> X TOWN <u>Rural</u> <u>Randallstown</u> STREET ADDRESS <u>Holbrook</u>	
3 NAME OF DECEASED (First) (Middle) (Last) <u>Mary</u> <u>S.</u> <u>Moffett</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>May</u> <u>7</u> <u>1955</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>W</u>	7 SINGLE MARRIED <u>Married</u>	8 DATE OF BIRTH <u>Sept. 2, 1868</u>
9 AGE last birthday <u>86</u> yrs		10 AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10A USUAL OCCUPATION Give kind of work done during most of working life even if retired <u>Housewife own home</u>		10B KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas Kelley</u>		14 MOTHER'S MAIDEN NAME <u>Virginia Brooks</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT & ADDRESS <u>Mr. S. T. Moffett, Randallstown, md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4221 IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSE (B) <u>Cardio-vascular disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>0</u>		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING OR CONTR BUT NG CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory, OF INJURY street, office bldg, etc)	
21C WHERE DID (City or town) (County) (State)		21D HOW DID INJURY OCCUR?	
21E INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>5/1/55</u> , 19 <u>55</u> , to <u>5/7/</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/6/</u> , 19 <u>55</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above. SIGNATURE <u>Mr. E. Martin</u> M D <u>Randallstown</u> DATE SIGNED <u>5/7/55</u>			
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Wards Chapel</u>		LOCATION, City, town, or county (State) <u>Baltimore Co., md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/7/55</u>		REGISTRAR'S SIGNATURE <u>Mr. E. Martin</u>	
FUNERAL DIRECTOR <u>Arthur H. Haight & Son, Inc., md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. C. 100-100000

100-100000-100000

04417

STATE DEPARTMENT OF HEALTH

MARYLAND

4346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY BALTO COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD COUNTY BALTO CT	
CITY (If outside corporate limits, write RURAL and give nearest town) ROSEMONT LENGTH OF STAY 1 month		CITY (If outside corporate limits, write RURAL and give nearest town) ROSEMONT	
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓		STREET ADDRESS (If rural, give location) 3010 ALABAMA AVE	
3. NAME OF DECEASED (Type or Print) ANNIE M. MYERS		4. DATE OF DEATH 5-18-1955	
5. SEX F	6. COLOR OF RACE WHITE	7. STATE AND YEAR OF BIRTH MD 1882	8. AGE last birthday 73 yrs. 3 mos. 8 days
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) NONE		11. BIRTHPLACE (State or foreign country) BALTO	
10b. KIND OF BUSINESS OR INDUSTRY ✓		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEONARD MARTIN		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) ✓		16. SOCIAL SEC. "ID" NO. ✓	
17. INFORMANT AND ADDRESS MRS GETZ 3010 ALABAMA AVE		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4201 Immediate cause (a) Coronary Occlusion		24 hours	
Antecedent cause(s) (b) Generalized Arteriosclerosis		unknown	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ✓			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) Hour		INJURY OCCURRED HOW DID INJURY OCCUR?	
OF INJURY m. While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 1-4-55 , 19 55 , to 5-18-55 , 19 55 , that I last saw the deceased alive on 5-17-55 , 19 55 , and that death occurred at 10⁰⁰A. m., from the causes and on the date stated above.			
SIGNATURE Nathan R. Gensin		ADDRESS 206 S. Gilmer ST DATE SIGNED 5-20-55	
23. PLACE OF BURIAL (Name of institution) BURIAL DATE 5/21/55		24. FUNERAL DIRECTOR WESTERN ADDRESS EDMONDSON AVE	
DATE REC'D BY LOCAL REG. 5-20-55		REGISTRAR'S SIGNATURE ✓ ADDRESS GEO. LEIMBACH 525 N. LYNB HURST ST	

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4435

CERTIFICATE OF DEATH

Reg. Dist. No.

044184

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u> <u>37 DAYS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY <u>...</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>REISTERSTOWN</u> STREET ADDRESS (If rural give location) <u>DOVER ROAD</u>	
3 NAME OF DECEASED (First) (Middle) (Last) <u>EDWARD C. MYERS</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>MAY 11 1955</u>	
5 SEX <u>MALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 SINGLE MARRIED <u>MARRIED</u> 8 DATE OF BIRTH <u>11-20-97</u>		9 AGE last birthday <u>57</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10A USUAL OCCUPATION Give kind of work done during most of working life even if retired <u>POSTAL CLERK</u>		10B KIND OF BUSINESS OR INDUSTRY <u>RAILWAY</u>	
11 FATHER'S NAME <u>JOHN E. MYERS</u>		12 BIRTHPLACE (State or foreign country) <u>BORING, MARYLAND</u>	
13 MOTHER'S MAIDEN NAME <u>ANNIE CROWTHER</u>		14 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give way or dates of service) <u>WW I</u>		16 SOCIAL SECURITY NO <u>Unknown</u>	
17 INFORMANT'S ADDRESS <u>CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>451X ANEURYSM OF POSTERIOR COMMUNICATING CEREBRAL ARTERY</u>		<u>UNKNOWN</u>	
ANTECEDENT CAUSE (S) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST</u>			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>Approx. 2-25-55</u>		19B MAJOR FINDINGS OF OPERATION <u>Ligation of aneurysm and branches of right middle cerebral artery.</u>	
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOT BY MEDICAL EXAMINER)		21B PLACE Home, farm, factory, street, office bldg, etc	
21C WHERE D.D. (City or town) (County) (State)		21D HOW DID INJURY OCCUR?	
21E TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M</u>		21F INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>APR. 4, 1955</u> , to <u>MAY 11, 1955</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William E. Vandergrift, M.D.</u>		DATE SIGNED <u>MAY 12-55</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>PLEASANT GROVE CEMETERY</u>	
DATE REC'D BY LOCAL REGISTRAR <u>MAY 16-55</u>		REGISTRAR'S SIGNATURE <u>Danison L. Harbor</u>	
24 FUNERAL DIRECTOR ADDRESS <u>Tipton Funeral Home, R Hampstead, Md.</u>			

BOARD OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

4436

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04419
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 30

1. PLACE OF DEATH:

COUNTY

Balto

MARYLAND

CITY (If outside corporate limits, write RURAL OR give nearest town)

TOWN Catonsville

LENGTH OF STAY (in this place)

Sept 2-16-53

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Catonsville Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE

Md

COUNTY

Balto

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Rural

STREET ADDRESS

1201 Elm Ridge Ave

3. NAME OF DECEASED:

(Type or Print)

(First)

Alice

(Middle)

Neilson

(Last)

4. DATE OF DEATH

(Month)

(Day)

(Year)

May 24 1953

5. SEX:

7

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

9-22-1880

9. AGE last birthday:

74

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Patrick Horn

14. MOTHER'S MAIDEN NAME:

Margaret Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No:

17. INFORMANT & ADDRESS:

Care of Toelle Elmridge

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

432.1

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

Cardiac decompensation

arterio-sclerotic Cardiac

Vascular disease

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

fracture of hip July 53

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION.

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

J. M. Kieffer

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM

DATE SIGNED

May 25 1953

23. BURIAL, CREMATION, REMOVAL (Specify):

Buried

DATE TO BE OF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

J. M. Kieffer

24. FUNERAL DIRECTOR

John J. Conangan

ADDRESS

Helm St.

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4437

CERTIFICATE OF DEATH

Reg. Dist. No.

04420

1 PLACE OF DEATH

COUNTY BALTIMORE MARYLAND
 (CITY If outside corporate limits write RURAL LENGTH OF STAY
 OR and give nearest town) (in this place)
 55 TOWN TOWSON 4 10 years
 HOSPITAL OR SHEPARD AND ENDICOTT HOSPITAL
 INSTITUTION OR
 13 STREET ADDRESS HOSPITAL TOWSON 4, Md.

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY TALBOT
 (CITY If outside corporate limits write R (R) and give nearest town)
 OR
 TOWN EASTON 20 40 2
 STREET ADDRESS (If rural give location)
 ADDRESS

3 NAME OF DECEASED (Type or Print)

(First) HELEN (Middle) THROP (Last) NICHOLSON

4 DATE OF DEATH

(Month) MAY (Day) 27 (Year) 1955

5 SEX

6 (COLOR OR RACE)
FEMALE WHITE

7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW

8 DATE OF BIRTH

9 AGE last birthday 84 yrs. Month 1 Day 27 Hour 12 Min

10a USUAL OCCUPATION Give kind of work done during most of working life, even if retired

HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) PITTSBURGH PENNA

12 (CITIZEN OF WHAT COUNTRY?) USA

13 FATHER'S NAME

JOHN MILLER THROP

14 MOTHER'S MAIDEN NAME

JANE VEEDEER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or ink) (If Yes give war or dates of service) No

16 SOCIAL SECURITY NO.

UNK

17 INFORMANT & ADDRESS

HOSPITAL RECORDS

18 MEDICAL CERTIFICATION

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause

(a) CARDIO-VASCULAR FAILURE

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) GENERALIZED ARTERIO SCLEROSIS

DUE TO

(c)

Interval Between Onset And Death

1 WEEK

10 YEARS

11 OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None SENILE PSYCHOSIS

19a DATE OF OPERATION

None

19b MAJOR FINDINGS OF OPERATION

None

20 AUTOPSY?

Yes ☒ No ☐

21 ACCIDENT

Specify

PLACE (Home farm factory street, office b.d.g. etc.)
 OF INJURY None

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22 I hereby certify that I attended the deceased from July, 1954, to MAY, 1955, that I last saw the deceased

alive on MAY 27, 1955, and that death occurred at 1:30 PM., from the causes and on the date stated above

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23 BURIAL CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

May 28 1955 R.W.

Dr. M. J. Dickner & Sons Balto 17 Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

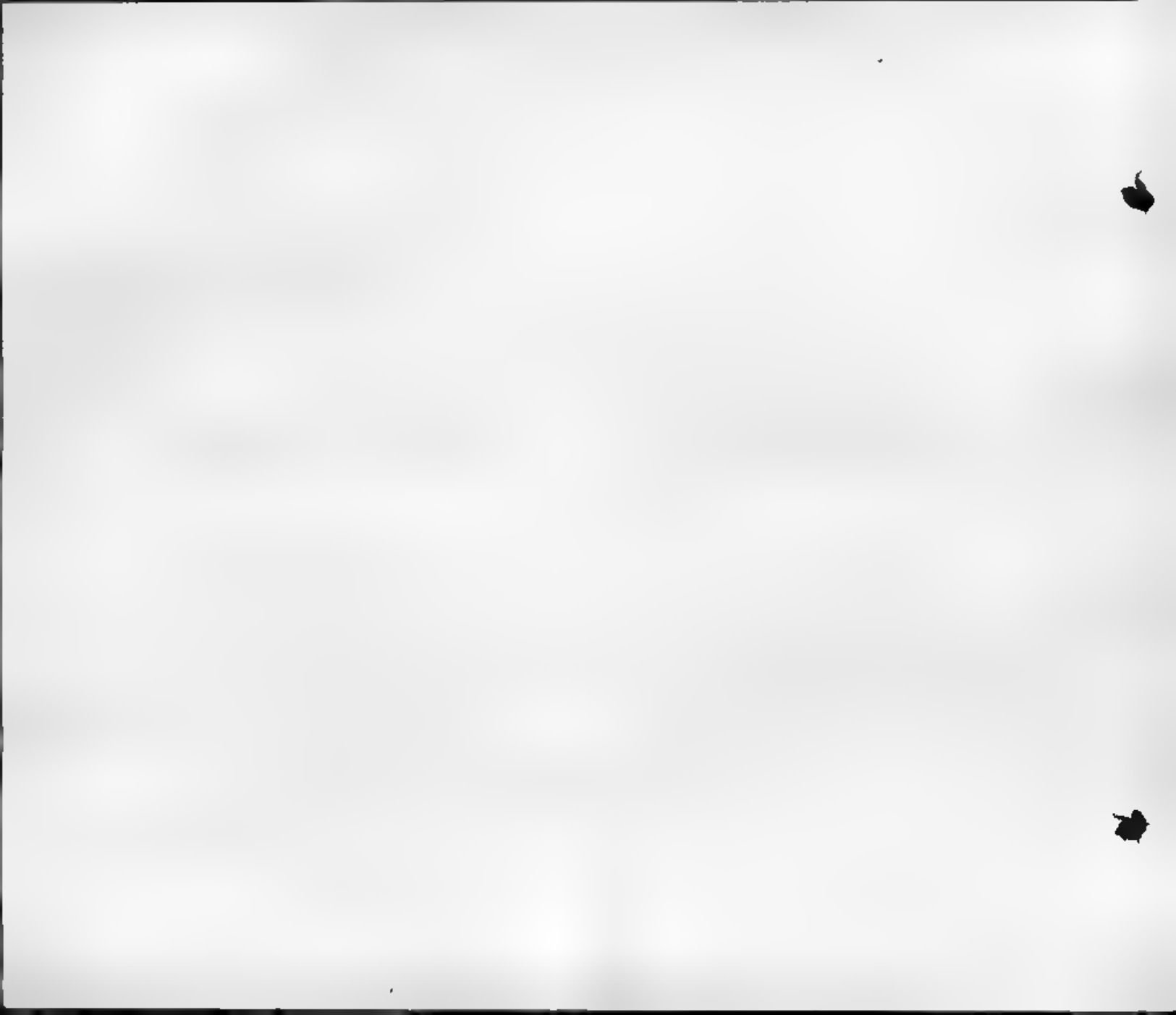
Reg. Dist. No.

4438

1 PLACE OF DEATH COUNTY <u>Balto.</u> CITY <u>Catonsville</u> OR TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines 16 Rusting Ave.</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>1041 Ridgely St.</u>	
3 NAME OF DECEASED (Type or Print) <u>LILLIAN I. NUFFER</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>May 11, 1955</u>	
5 SEX <u>female</u> 6 COLOR OR RACE <u>white</u> 7 SINGLE MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8 DATE OF BIRTH <u>June 6, 1889</u> 9 AGE last birthday <u>65</u> IF UNDER 1 YEAR Months Days Hours Min	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Inspector</u>		10B KIND OF BUSINESS OR INDUSTRY <u>Glass Mfg.</u>	
13 FATHER'S NAME <u>James McKeldin</u>		14 MOTHER'S MAIDEN NAME <u>Lora Grief</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service <u>No</u>		17 INFORMANT'S ADDRESS <u>Mr. Robert Nuffer - 1041 Ridgely St.</u>	
18 MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>Hypertensive Cardiovascular Systr</u>			
ANTECEDENT CAUSE (B) <u>Liverase</u>			
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>5/10/55</u>		19B MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING CAUSE OF DEATH? IF EITHER NOTIFY MEDICAL EXAMINER		21B PLACE (Home, farm, factory, etc.) OF INJURY	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E INJURY OCCURRED While at work Not while at work		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/4/55</u> to <u>5/11/55</u> , that I last saw the deceased alive on <u>5/10/55</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above			
SIGNATURE <u>John R. Stawo</u> M.D.		DATE SIGNED <u>5/12/55</u>	
23 BURIAL CREMATION: DATE THEREOF <u>5/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	
REMOVAL (Specify)		LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>	
DATE REC'D BY LOCAL REGISTRARS SIGNATURE <u>W. Hedrick</u>		FUNERAL DIRECTOR ADDRESS <u>John R. Stawo, Balto Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4439

CERTIFICATE OF DEATH

Reg. Dist. No.

04422-

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND CITY If outside corporate limits write RURAL LENGTH OF STAY OR and give nearest town (in this place) TOWN <u>Essex, Md.</u> <u>70 yrs.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>160 Wiltshire Rd.</u>		STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY If outside corporate limits, write RURAL and give nearest town TOWN <u>Essex, Md.</u> STREET ADDRESS (If rural give location) <u>160 Wiltshire Rd.</u>	
3 NAME OF DECEASED (First) (Middle) (Last)		4 DATE (Month) (Day) (Year) OF DEATH	
<u>Andrew</u> (Type or Print) 5 SEX <u>M.</u> 6 COLOR OR RACE <u>W.</u> 7 SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u> 8 DATE OF BIRTH <u>May 11 - 1875</u> 9 AGE <u>79</u> yrs.		<u>May 7</u> 19 <u>55</u> 10 MONTH DAYS Hours Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		11 BIRTHPLACE (State or foreign country)	
		<u>Austria</u>	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
<u>Joseph Oschab</u>		<u>Regina</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give way or dates of service)		17 INFORMANT'S ADDRESS	
		<u>Mrs. Anna Oschab</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u> ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)		<u>Sudden</u> <u>Generalized Arteriosclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc)	
		21C WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While at work Not while at work	
		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>May</u> , 19 <u>58</u> that I last saw the deceased alive on <u>May 4</u> , 19 <u>58</u> and that death occurred at <u>A. M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Wm. A. Rogers</u>		<u>May 7, 1955</u>	
23 BURIAL, CREMATION, REMOVAL, (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Sacred Heart of Mary Roman Hill Rd. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24 FUNERAL DIRECTOR	
<u>5-7-55</u>		<u>John J. Buda Hudson & Liwood</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04423

4440

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Baltimore Co.</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Pikesville</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Pikesville</i>	
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<i>204 Subbrook Lane, Pikesville</i>	
3 NAME OF DECEASED (First) (Middle) (Last)		4 DATE (Month) (Day) (Year)	
<i>JAMES FRED OFFUTT</i>		<i>MAY 18 1955</i>	
5 SEX <i>MALE</i>	6 COLOR OR RACE <i>WHITE</i>	7 SINGLE MARRIED <i>MARRIED</i>	8 DATE OF BIRTH <i>MAY 28, 1875</i>
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10B KIND OF BUSINESS OR INDUSTRY	9 AGE last birthday <i>79</i> yrs. <i>18</i> Months <i>18</i> Days <i>18</i> Hours <i>18</i> Min
11 FATHER'S NAME <i>James Worthington Offutt</i>		12 CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13 MOTHER'S MAIDEN NAME <i>Elizabeth Frances Cockey</i>		14 BIRTHPLACE (State or foreign country) <i>Baltimore Co. Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO. <i>...</i>	
17 INFORMANT'S ADDRESS <i>Edward Jones Mason</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1440 IMMEDIATE CAUSE (A) <i>Uremia</i>		<i>2 weeks</i>	
ANTECEDENT CAUSE (B) <i>Chronic Nephritis</i>		<i>few years</i>	
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <i>Arterio-sclerosis, generalized</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <i>Pneumonia, left lung</i>			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
<i>1</i>			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory of INJURY street, office bldg., etc)	
		21C WHERE D.D. (City or town) (County) (State)	
21D TIME (Month, (Day) (Year) (Hour) OF INJURY <i>M.</i>		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1955</i> to <i>May, 1955</i> , that I last saw the deceased alive on <i>May 27, 1955</i> , and that death occurred at <i>12 M.</i> from the causes and on the date stated above.			
SIGNATURE <i>David Salzman</i>		DATE SIGNED <i>5/19/55</i>	
23 BURIAL CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 21, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>David Ridge Cemetery</i>		LOCATION (City, town or county) <i>Pikesville Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/30/1955</i>		REGISTRAR'S SIGNATURE <i>Harriet A. Jewell</i>	
		FUNERAL DIRECTOR <i>Frank H. Howell</i>	
		ADDRESS <i>Pikesville</i>	

BUREAU V. S.

NO. 11

RECEIVED
JUL 11 1894

4441

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u> 6 HRS. 25 MIN. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>6514 MOUNT VERNON AVENUE</u>			
3 NAME OF DECEASED (First) (Middle) (Last) <u>ROBERT Winfield OLER</u>				4 DATE (Month) (Day) (Year) OF DEATH <u>MAY 17 1955</u>			
5 SEX <u>MALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 SINGLE MARRIED WIDOWED DIVORCED <u>SINGLE</u> 8 DATE OF BIRTH <u>7/29/89</u> 9 AGE last birthday <u>65</u> yrs Months Days Hours Min				10A USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>PAINTER</u> 10B KIND OF BUSINESS OR INDUSTRY _____			
11 BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>				12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13 FATHER'S NAME <u>JOSH P. OLER</u>				14 MOTHER'S MAIDEN NAME <u>MARTHA SMITH</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If Yes give year or dates of service, <u>WW I</u>				16 SOCIAL SECURITY NO. <u>217-05-1274</u>			
17. MEDICAL CERTIFICATION				17. INFORMANT & ADDRESS <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>			
18 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE <u>422.1</u>				<u>10 HRS.</u>			
(B) ANTECEDENT CAUSE (8)				<u>UNKNOWN</u>			
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST				(C) _____			
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A DATE OF OPERATION				19B MAJOR FINDINGS OF OPERATION			
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)				21B PLACE Home, farm, factory OF INJURY street office bldg etc			
21C WHERE DID (City or town) (County) (State)				21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M</u>			
21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F HOW DID INJURY OCCUR? <u>9:10 PM 3:35 AM</u>			
22. I hereby certify that I attended the deceased from <u>MAY 16 1955</u> , to <u>MAY 17 1955</u> and that death occurred at <u>3:35 AM</u> , from the causes and on the date stated above							
SIGNATURE <u>F. S. Donkey</u>				ADDRESS <u>VAH, Fort Howard, Maryland</u>			
DATE SIGNED <u>5-17-55</u>							
23 BURIAL CREMATION DATE THEREOF				NAME OF CEMETERY OR CREMATORY			
REMOVAL (SPECIFY) <u>Burial</u>				LOCATION (City town or county) (State) <u>Baltimore, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5-18-55</u>				REGISTRAR'S SIGNATURE <u>Carroll H. Edwards</u>			
FUNDAL DIRECTOR ADDRESS <u>Loring Evers Funeral Home</u>				ADDRESS <u>5005 Park Heights Ave., Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



4442

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN NorthbrookHOSPITAL OR
INSTITUTION OR
STREET ADDRESS7729 Eastdale Road

MARYLAND

LENGTH OF STAY
(in this place)

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Northbrook

STREET ADDRESS (If rural give location)

7729 Eastdale Road3 NAME OF
DECEASED
(Type or Print)

First

(Middle)

(Last)

MARYALICEOLIFF

5 SEX

6

COLOR OR

7 SINGLE

MARRIED

8

DATE OF BIRTH

9 AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS

female

1

white

SPECIFY

Widowed Sept. 3, 187381

vts

Months

Days

Hours

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B KIND OF BUSINESS OR INDUSTRY

at home

11 BIRTHPLACE (State or foreign country)

Virginia

12 CITIZEN OF WHAT COUNTRY

U. S. A.

13 FATHER'S NAME

Richard Scates

14 MOTHER'S MAIDEN NAME

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT'S ADDRESS

Edith Campbell, 7729 Eastdale Road

18. MEDICAL CERTIFICATION

DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IX

IMMEDIATE CAUSE

(A)

Cerebral Hemorrhage

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

Hypertension

(C)

19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

INTERVAL BETWEEN ONSET AND DEATH

6 days

19A DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY?

YES ☐ NO ☐

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, street, office bldg etc)

21C WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

M

21E INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1960, to May 18, 1960, that I last saw the deceasedalive on May 17, 1960, and that death occurred at 4:30 P.M. from the causes and on the date stated aboveSIGNATURE David Schneider

ADDRESS

M.D. 11010 N. Belton Ave

DATE SIGNED

5-18-60

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City or town or county)

(State)

burial5/21/60Oak Lawn CemeteryBaltimore County, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

5-19-60A. W. [Signature]Wm. Bark Inc., 1217 St. Paul Street

MARGIN RESERVED FOR BINDING

4.

5.

4443

CERTIFICATE OF DEATH

04426

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE MARYLAND		STATE W.Va.		COUNTY Greenbrier	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN White Marsh		2 wks.		TOWN Otto		X -	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Oscar Oliver				May, 11, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
male	white	married	Oct. 15, 1894	60 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Owner,		North Carolina		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) (If affirmative give year or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS			
yes		W.R. I		406-12-1932			
				Mrs. Bessie Oliver, White Marsh, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A)				CARCINOMATOSIS			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				CARCINOMA OF THE STOMACH			
STATING UNDERLYING CAUSE LAST DUE TO (C)				18+ MOS			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21c. WHERE DID INJURY OCCUR? (City or town) (County) State,			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11 MAY, 1955 , to 11 MAY, 1955 , that I last saw the deceased alive on 11 MAY, 1955 , and that death occurred at 9⁰⁰ P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
Marvin G. Epstein		M.D. 12 Yahde St. Edgewood, Md.		12 May 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
Removal		May, 12, 1955		Wallace & Wallace, F.H.		Lewisburg, Greenbrier, W.Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
5/20/55		Gaith Hurley		Howard K. McComas & Son, Abingdon, Md.		Howard K. McComas & Son	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

5% 1000000

May 20 1954

27

4444

CERTIFICATE OF DEATH

Reg Dist No.

04427

1 PLACE OF DEATH

COUNTY BaltimoreCITY (If outside corporate limits, write RURAL and give nearest town)
OR Baltimore MARYLAND
TOWN Baltimore LENGTH OF STAY
(in this place)
5 yearsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS7928 E 32nd St

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY BaltimoreCITY (If outside corporate limits, write RURAL and give nearest town)
OR Baltimore, Md.

STREET ADDRESS (If rural give location)

7928 E 32nd St.3 NAME OF
DECEASED
(Type or Print)First Irene(Middle) Louise(Last) O'Neill4 DATE (Month) (Day) (Year)
OF DEATH May 23 1955

5 SEX

Female6 COLOR OR
White7 SINGLE MARRIED
WIDOWED DIVORCED
Specify Widow

8 DATE OF BIRTH

Jan 3 18929 AGE last birthday FUND YEAR IF UNDER 18
Months Days Hours Min
63 10 23 15

10A USUAL OCCUPATION Give kind of work done during most of working life even if retired

Housewife

10B KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country)

Ill.

12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME

Elmer E. Bour14 WAS DECEASED EVER IN U.S. ARMY OR FORCE?
(Yes, no, or unk) (If Yes, give year or dates of service)

15 SOCIAL SECURITY NO

17 INFORMANT & ADDRESS

Wm Kennedy - Wmell 7 S

18 MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X

IMMEDIATE CAUSE

(A)

Carcinoma of the Cervix

ANTECEDENT CAUSE (B)

DUE TO

DISEASES OR CONDITIONS, IF ANY
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A DATE OF OPERATION 19B MAJOR FINDINGS OF OPERATION

21A ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either notify medical examiner)21B PLACE (Home, farm, factory
OF INJURY street, office bldg., etc.)21C WHERE DID CITY OR TOWN (County)
INJURY OCCUR? (State)21D TIME (Month) (Day) (Year) (Hour)
OF INJURY

M

21E INJURY OCCURRED
While at work Not while at work

21F HOW DID INJURY OCCUR?

20. AUTOPSY?
YES ☐ NO ☒22 I hereby certify that I attended the deceased from April 1953, to May 1955, that I last saw the deceased alive on May 21 1955, and that death occurred at 5:20A M from the causes and on the date stated above.

SIGNATURE

John R. Munn M.D.

ADDRESS

8019 Philadelphia Rd.

DATE SIGNED

May 23, 195523 BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

Se 23-03 - J. R. Munn Arlington Cemetery Drexel Hotel 1217 St Paul St

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04428

4445

CERTIFICATE OF DEATH

Reg. Dist. No.

35

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL, and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL, and give nearest town)	
X TOWN <u>Freeland</u>	<u>1 yr.</u>	OR TOWN <u>Freeland</u>	X
HOSPITAL OR NSTITUTION OR STREET ADDRESS <u>Ruhl Rd.</u>		STREET ADDRESS (If rural give location) <u>Ruhl Rd.</u>	
3 NAME OF DECEASED (First) (Middle) (Last)	4 DATE (Month) (Day) (Year)	5 DATE OF DEATH (Month) (Day) (Year)	
<u>Fount C Owens</u>	<u>May 24, 1955</u>	<u>May 24, 1955</u>	
6 SEX <u>M</u>	7 COLOR OR RACE <u>W.</u>	8 SINGLE MARRIED WIDOWED DIVORCED <u>Married</u>	9 AGE last birthday <u>61</u> yrs
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZENSHIP OF WHAT COUNTRY?
<u>Carpenter</u>	<u>Carpentering</u>	<u>Smith Co, Va</u>	<u>U. S. A.</u>
13 FATHER'S NAME <u>Sherwood Owens</u>	14 MOTHER'S MAIDEN NAME <u>Josie Johnson</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)	16 SOCIAL SECURITY NO <u>403-01 5513</u>	17 INFORMANT'S ADDRESS <u>Mrs. Stanley Impacher, Freeland, Md.</u>	
18 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>162X</u>		<u>Mar. 1954</u>	
ANTECEDENT CAUSE (B) <u>Branchogenic Carcinoma with metastases</u>		<u>to</u>	
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Portal cirrhosis</u>		<u>May 24, 1955</u>	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
<u>Portal cirrhosis</u>			
19A DATE OF OPERATION <u>April 6, 1954</u>	19B MAJOR FINDINGS OF OPERATION <u>Branchogenic Carcinoma of lung, Carcinoma of left kidney.</u>		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)	21B PLACE (Home, farm, factory, office, street, office bldg., etc)	21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-29, 1954</u> , to <u>5-24, 1955</u> , that I last saw the deceased alive on <u>5-24, 1955</u> , and that death occurred at <u>7-25 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Richard F. Johnson</u>		ADDRESS <u>M D New Freedom, Pa.</u>	DATE SIGNED <u>5-25-55</u>
23 BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 27, 1955</u>	<u>Mt. Zion Cemetery</u>	<u>Freeland, Md.</u>
DATE REC'D BY LOCAL REG. STR.	REGISTER'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>5/26/55</u>	<u>Charles F. Freeland</u>	<u>Freeland</u>	<u>New Freedom, Pa.</u>

U. S. A. 1947

MARYLAND

STATE DEPARTMENT OF HEALTH

4446

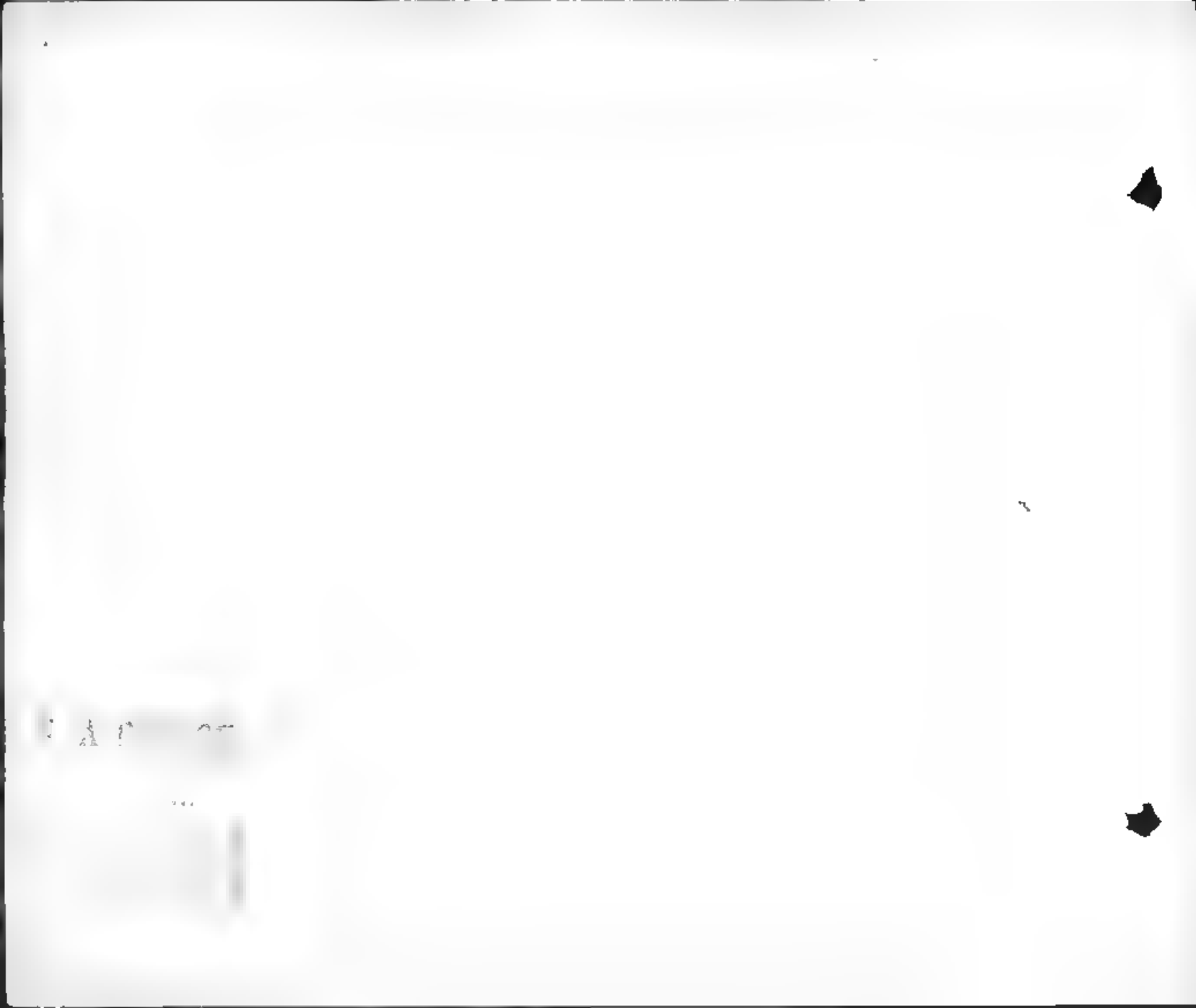
CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glyndon		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glyndon	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 Chatsworth Ave.		STREET ADDRESS 2 Chatsworth Ave.	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Walter W. Penn		4. DATE OF DEATH (Month) (Day) (Year) May 8, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH May 19, 1932
9. AGE last birthday 72 yrs.		10. AGE last birthday 72 yrs.	
11. BIRTHPLACE (State or foreign country) Perry Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Penn		14. MOTHER'S MAIDEN NAME Emma V. McCaulley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. 165-10-1783	
17. INFORMANT AND ADDRESS Mrs. J. Alden Smith, Glyndon, Md.			

18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.2 Immediate cause (a) Coronary Artery Disease				2 yrs 4 mos.	
Antecedent cause(s) (b) Angina Pectoris				2 yrs 4 mos.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None.					
20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
21. DATE OF OPERATION None		22. MAJOR FINDINGS OF OPERATION None		23. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
24. ACCIDENT (Specify) None		25. PLACE (Home, farm, factory, street, or office bldg., etc.) None		(CITY OR TOWN) (COUNTY) (STATE)	
26. TIME (Month) (Day) (Year) (Hour) OF INJURY None		27. INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>		28. HOW DID INJURY OCCUR? None	
29. I hereby certify that I attended the deceased from 9-25 , 1947, to 5-8 , 1955, that I last saw the deceased alive on 5-7 , 1955, and that death occurred at 1 P m., from the causes and on the date stated above.					
SIGNATURE J. D. Elyne		ADDRESS M. D. Reisterstown, Md.		DATE SIGNED 5-10-55	
30. BURIAL, CREMATION REMOVAL (Specify) Burial		31. DATE May 11, 1955		32. NAME OF CEMETERY OR CREMATORY All-Saints	
33. DATE REC'D BY LOCAL REG 5-11-55		34. REGISTRAR'S SIGNATURE Mary B. Elyne		35. FUNERAL DIRECTOR ADDRESS J. F. Elyne & Sons, Reisterstown, Md.	

MARGIN RESERVED FOR BINDING



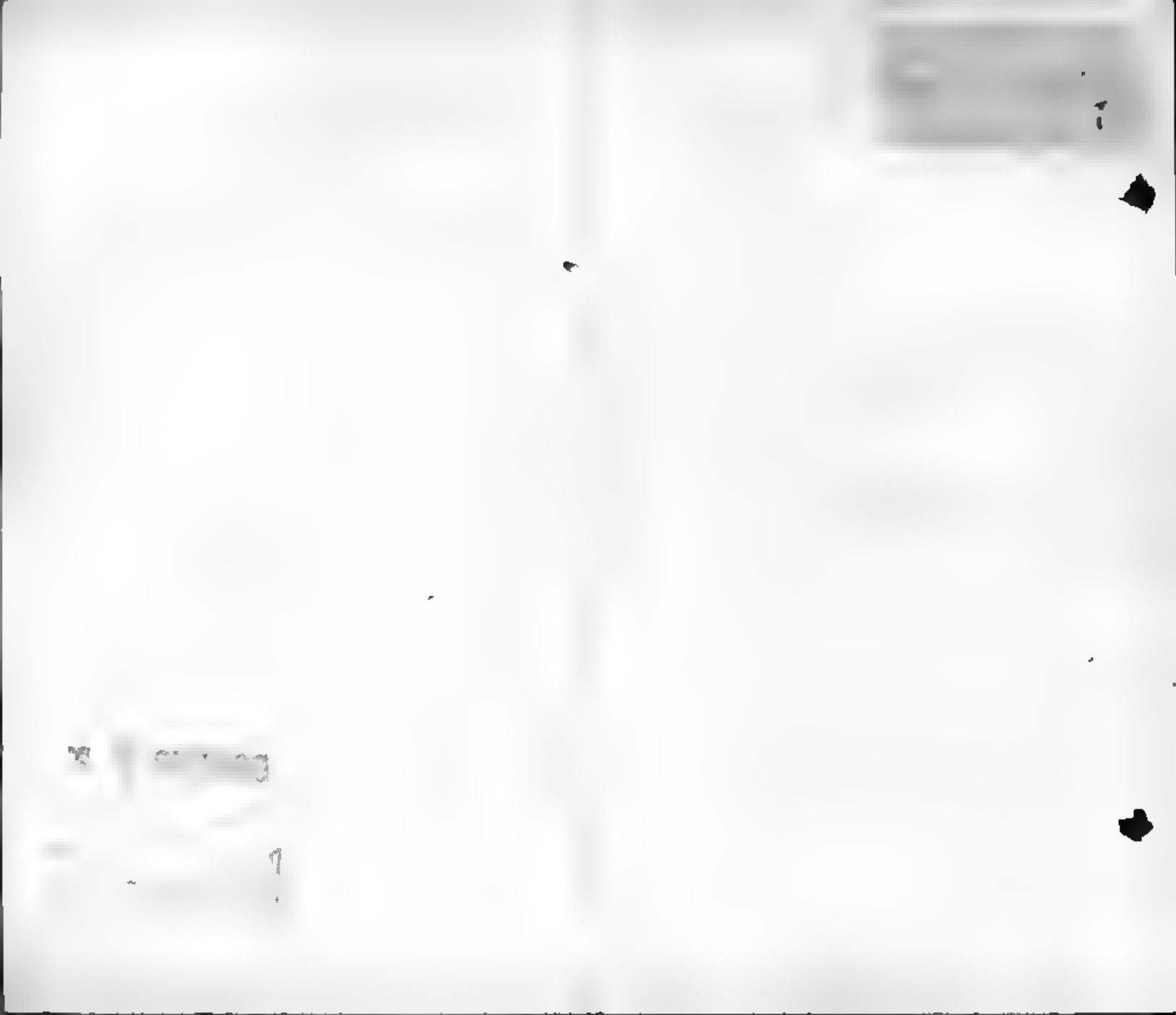
CERTIFICATE OF DEATH

Reg. Dist. No.

47

1 PLACE OF DEATH <i>Baltimore County</i>		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Graddec's Nursing Home</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>MARYLAND</i> OR TOWN <i>Halethorpe Md.</i> LENGTH OF STAY (in this place) <i>1 yr. 2 mo.</i>		STATE <i>MD.</i> COUNTY <i>Baltimore</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> OR TOWN <i>Baltimore</i> STREET ADDRESS (If rural give location) <i>1029 Stricker Street</i>	
3 NAME OF DECEASED (Type or Print) <i>William</i> (First) <i>Pickett</i> (Last)		4. DATE (Month) (Day) (Year) <i>May 3 1955</i>	
5 SEX <i>Male</i> 6 COLOR OR RACE <i>Negro</i> 7 SINGLE MARRIED WIDOWED DIVORCED <i>unknown</i>		8 AGE last birthday <i>47</i> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>	
11 FATHER'S NAME <i>unknown</i>		12 CITIZEN OF WHAT COUNTRY? <i>unknown</i>	
13 MOTHER'S MAIDEN NAME <i>unknown</i>		14 MOTHER'S MAIDEN NAME <i>unknown</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
352X IMMEDIATE CAUSE (A) <i>Hemiplegia + Epilepsy</i>			
ANTECEDENT CAUSE (B) <i>Cardiac Disease</i>			
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20 ALTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory of INJURY street, office bldg., etc)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
22. I hereby certify that I attended the deceased from <i>Nov 16, 1954</i> to <i>May 3, 1955</i> , that I last saw the deceased alive on <i>3-3</i> , 1955, and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above			
SIGNATURE <i>Dr. J. M. Keiffer</i> ADDRESS <i>Elkridge Md</i> DATE SIGNED <i>May 3 1955</i>			
23 BURIAL CREMATION REMOVAL (SPECIFY) <i>Stored</i> DATE THEREOF <i>June 2, 1955</i> NAME OF CEMETERY OR CREMATORY <i>Union 3 Maryland Med. Sch., Balto., Maryland</i>			
DATE REC'D BY LOCAL REGISTRAR <i>June 24, 1955</i> REGISTRAR'S SIGNATURE <i>Dr. J. M. Keiffer</i>		24 FUNERAL DIRECTOR ADDRESS <i>The Anatomy Board of Maryland</i>	

MARGIN RESERVED FOR BINDING



04430

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

4447

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville P.O.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
TOWN <u>Cockeysville P.O.</u>		TOWN <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore County Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>NATHAN</u> (Middle) <u>PLUMMER</u> (Last) <u>PLUMMER</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify <u>WIDOWED</u>)		8. DATE OF BIRTH <u>MARCH 10, 1874</u>	
9. AGE last birthday <u>81</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
12. FATHER'S NAME <u>WILLIAM PLUMMER</u>		13. MOTHER'S MAIDEN NAME <u>HARRIET CLARK</u>	
14. WAS DISCHARGED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		15. SOCIAL SECURITY NO. <u>none</u>	
16. INFORMANT AND ADDRESS <u>Mrs. Marie Plummer 1519 Middleborough Rd</u>		17. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>42.1</u> <u>Arteriosclerotic cardio-vascular disease</u>		<u>years.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>cellulitis R+ hand</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>3 days.</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SHOCK HOMICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>	INJURY OCCURRED <u>While at Work</u> <input type="checkbox"/> <u>Not While at Work</u> <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Mar 24, 1955</u> to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>7:30 p.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>Elizabeth B. Sherrill, M.D.</u>		ADDRESS <u>Cockeysville, Md.</u>	
DATE SIGNED <u>5/16/55</u>			
23. BURIAL OR CREMATION REMOVAL (Specify) <u>Removal</u>	DATE <u>5/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	LOCATION (City, town, or county) <u>St. Ignace</u>
DATE REC'D BY LOCAL REG. <u>May 16/55</u>	REGISTER'S SIGNATURE <u>Wm. J. Robinson</u>	FUNERAL DIRECTOR <u>James J. Buehler</u>	ADDRESS <u>1407 Eastern Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

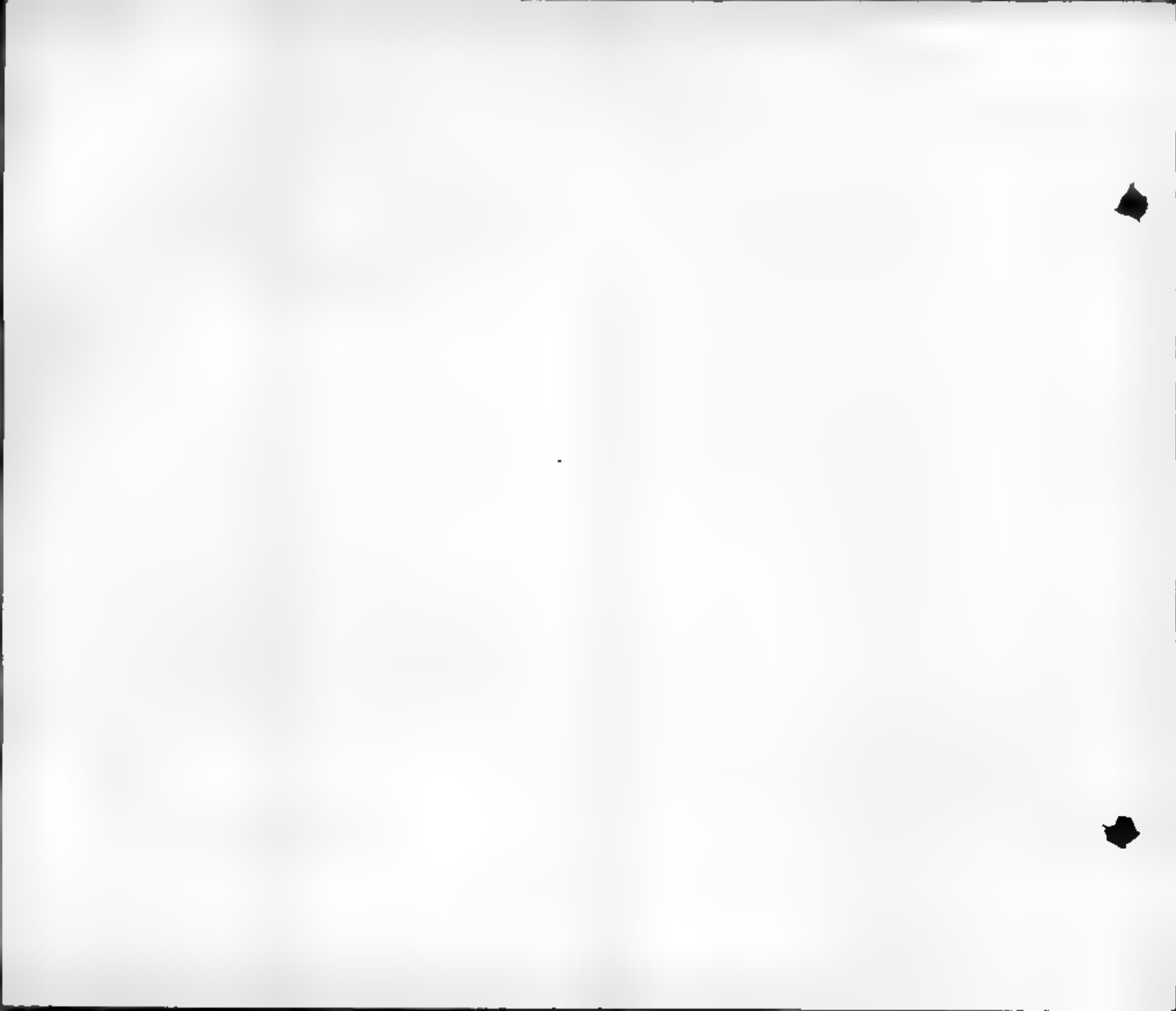
4449

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04432

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u> Md. </u> COUNTY			
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) <u>Catonsville 28</u> <u>1496 days</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u> <u>23</u> <u>yr</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St Hospital</u> <u>Catonsville 28 Md.</u>				STREET ADDRESS (If rural, give location) <u>109 N. Carey St.</u>			
3 NAME OF DECEASED (First) (Middle) (Last) <u>Hazel</u> <u>PRELLER</u>				4 DATE OF DEATH Month (Day) (Year) <u>5</u> - <u>30</u> - <u>1955</u>			
5 SEX <u>feem.</u> 6 COLOR OR RACE <u>w.</u> 7 SINGLE MARRIED, WIDOWED, DIVORCED <u>wid.</u>				8 DATE OF BIRTH <u>4.18.1894</u> 9 AGE last birthday <u>61</u> yrs (If under 1 year, give Months Days Hours Min)			
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10B KIND OF BUSINESS OR INDUSTRY			
11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>Arthur (last-unknown)</u>				14 MOTHER'S MAIDEN NAME <u>Certunde (last-unknown)</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> If Yes, give war or dates of service				16 SOCIAL SECURITY NO <u>unk.</u>			
17 INFORMANT & ADDRESS <u>This Hospital's Records</u>				18. MEDICAL CERTIFICATION			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>443X</u>				<u>unknown</u>			
ANTECEDENT CAUSE (S)				<u>unknown</u>			
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <u>(1924.9)</u>				<u>unknown</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Fracture of the left femur</u>				<u>8 months</u>			
19A DATE OF OPERATION <u>U</u>				19B MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
2A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21B PLACE Home, farm, factory of INJURY street office bldg etc			
21C WHERE DID INJURY OCCUR? City or town (County) (State)							
21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>1/19</u> , 1954, to <u>5/30</u> , 1955, that I last saw the deceased alive on <u>5/30</u> , 1955, and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bruno Radauskas</u>				ADDRESS <u>M.D. Spring Grove St Hospital</u>			
DATE SIGNED <u>5/30/55</u>							
23 BURIAL CREMATION OR REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>June 2, 1955</u>			
NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>				LOCATION (City town or county) (State) <u>Ritchie Highway</u>			
DATE REC'D BY LOCAL REG STRAR <u>6/4/55</u>				REGISTRAR'S SIGNATURE <u>W. W. H. H. H.</u>			
FUNERAL DIRECTOR <u>J. J. J. J.</u>				ADDRESS <u>1318 Light</u>			



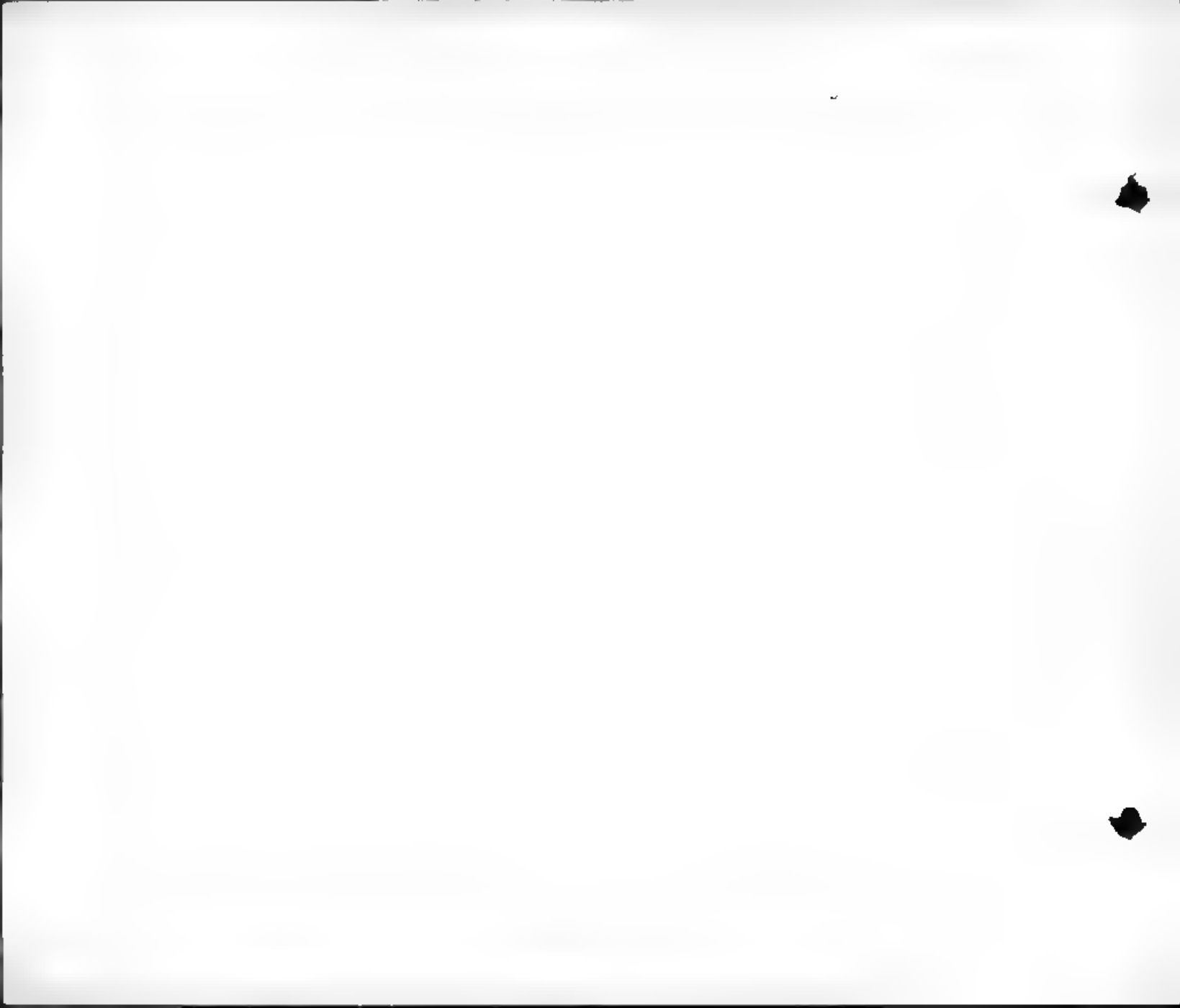
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 13, 14, Film G182 6-7-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY — <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> OR TOWN <u>Relay</u> LENGTH OF STAY <u>4 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relay Hall Hospital</u>		STATE <u>Maryland</u> COUNTY — CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>Relay</u> STREET ADDRESS <u>205 E Preston</u> (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>GILBERT R. PRODDFOOT</u>		<u>May 25 1955</u>	
5. SEX. <u>Male</u>		6. DATE OF BIRTH	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. AGE last birthday: <u>84</u> yrs. Months Days Hours Min.	
9. COLOR OR RACE: <u>White</u>		10. KIND OF BUSINESS OR INDUSTRY: <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>"No record"</u>		14. MOTHER'S MAIDEN NAME: <u>"No record"</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u>4</u>		16. SOCIAL SECURITY No.: <u>11261871</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Pulmonary edema</u> Antecedent cause(s) (b) <u>Arteriosclerotic heart disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Bilateral vaginal hernias</u>			
Interval Between Onset And Death: <u>1 hour</u>			
19. DATE OF OPERATION: <u>5/21</u> 19 <u>55</u> 20. AUTOPSY? <u>?</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED (While at Work) (Not While at Work) HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/21</u> , 19 <u>55</u> , to <u>5/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/29</u> 19 <u>55</u> , and that death occurred at <u>2:20 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>John P. Mundy, M.D.</u> ADDRESS <u>Relay 23, Md.</u> DATE SIGNED <u>5/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)			
<u>Burial</u> <u>5/27/55</u> <u>Louisa Park</u> <u>Balto. Md.</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR <u>26-35 / SW Hadrock</u> 24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook Inc., 1217 St. Paul St.</u>			



4448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Essey</u>				TOWN <u>Essey</u>		54	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>104 N. Stuart Ave.</u>				STREET ADDRESS <u>104 N. Stuart Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Frank - Buchniowski</u> (PETERSON)				DEATH: <u>5-20</u> 19 <u>55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 27 - 1895</u>	
						9. AGE last birthday: IF UNDER 1 YEAR IF OVER 24 HRS Months Days Hours Min <u>60</u> yrs. <u>3</u> <u>24</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, when if retired: <u>Electrician Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Maritime Trust</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <u>William Buchniowski</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Buchniowski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) If Yes, give war or dates of service				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Mrs. Mary Buchniowski (Wife)</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
165X Immediate cause (a) <u>Pulmonary edema</u>							
Antecedent cause(s) (b) <u>Pulmonary catarrh</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
2. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		OF INJURY					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>5/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>55</u> , and that death occurred at <u>3:18</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				(DEGREE OR TITLE) <u>MD</u>		ADDRESS <u>Essey</u> DATE SIGN'D <u>5/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION City, town or county (State)	
<u>Burial</u>		<u>5-24-55</u>		<u>Oak Lawn</u>		<u>Eastern Blk. Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/23/55</u>		<u>[Signature]</u>		<u>John S. Connelly</u>		<u>Essey Md.</u>	

MARGIN RESERVED FOR BINDING



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4337 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04434
Reg. Dist.

No 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits write RURAL OR and nearest town) <u>Baltimore 22</u>	LENGTH OF STAY (In this place) <u>12</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>21. Denver Colo 123</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>211 German Hill Rd - Gray Manor</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>John Nelson Redcay</u>		<u>May 22 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR HAIR <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Nov 27-1918</u>
9. AGE last birthday: <u>36 yrs.</u>		10. AGE last birthday: IF UNDER 1 YEAR: Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life) <u>Mechanics</u>		11. KIND OF BUSINESS OR INDUSTRY <u>P.A. R.R.</u>	12. BIRTHPLACE (State or foreign country) <u>Pa.</u>
13. FATHER'S NAME: <u>James Leon Redcay</u>		14. MOTHER'S MAIDEN NAME: <u>Blanch Reinbold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or U.S. 1) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No.: <u>712-26-0913</u>	
		17. INFORMANT & ADDRESS: <u>Thm. Redcay (brother)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5-10 min</u> <u>over 1 yr.</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) DUE TO <u>Coronary occlusion</u>	Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Coronary occlusion</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		(State)
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY	21c. (City or town, County, State)
21d. TIME (Month, Day, Year) (Hour) <u>May 22 5 22 55 PM</u>	21e. INJURY OCCURRED White at work <input checked="" type="checkbox"/> Not white at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Emilio M. D.</u>		DATE SIGNED
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-25-55</u>
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>11th. Md</u>
DATE REC'D BY LOCAL REG <u>5-25-55</u>		REGISTRAR'S SIGNATURE <u>W. B. Redcay</u>
24. FUNERAL DIRECTOR <u>W. B. Redcay</u>		ADDRESS <u>Baltimore, Md.</u>

11/11/11

AV 11 1955

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04435

4450

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>617 HILLTOP ROAD</u>		STREET ADDRESS (If rural, give location) <u>617 HILLTOP ROAD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>SUSIE</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>REPP</u>
4. DATE OF DEATH	(Month) <u>MAY</u>	(Day) <u>12</u>	(Year) <u>1955</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-4-65</u>
9. AGE last birthday <u>89</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN SEIPPEL</u>	
14. MOTHER'S MAIDEN NAME <u>SUSAN SCHLOTTMAIER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year give war or dates of service) <u>NONE</u>	
16. SOCIAL SECURITY No. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>HELEN SCHLOTTMAIER, 617 HILLTOP RD</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Hypertensive A.S.C.V.D.</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	(CITY OR TOWN) (COUNTY) (STATE)
HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>4/2</u> , 1955, to <u>5/12</u> , 1955 that I last saw the deceased alive on <u>5/12</u> , 1955 and that death occurred at <u>6:30</u> p.m., from the causes and on the date stated above.		
SIGNATURE <u>John P. Stealy M.D.</u>	ADDRESS <u>Baltimore, Md.</u>	DATE SIGNED <u>5/13/55</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>5-16-55</u>	NAME OF CEMETERY OR CREMATORY <u>London Park</u>
LOCATION (City, town, or county) <u>BALTIMORE</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/14/55</u>	REGISTRAR'S SIGNATURE <u>V.G. Harry</u>	24. FUNERAL DIRECTOR <u>George L. Schwab</u>
ADDRESS <u>2101 Frederick Ave. Baltimore, Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10-22-51 V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4151

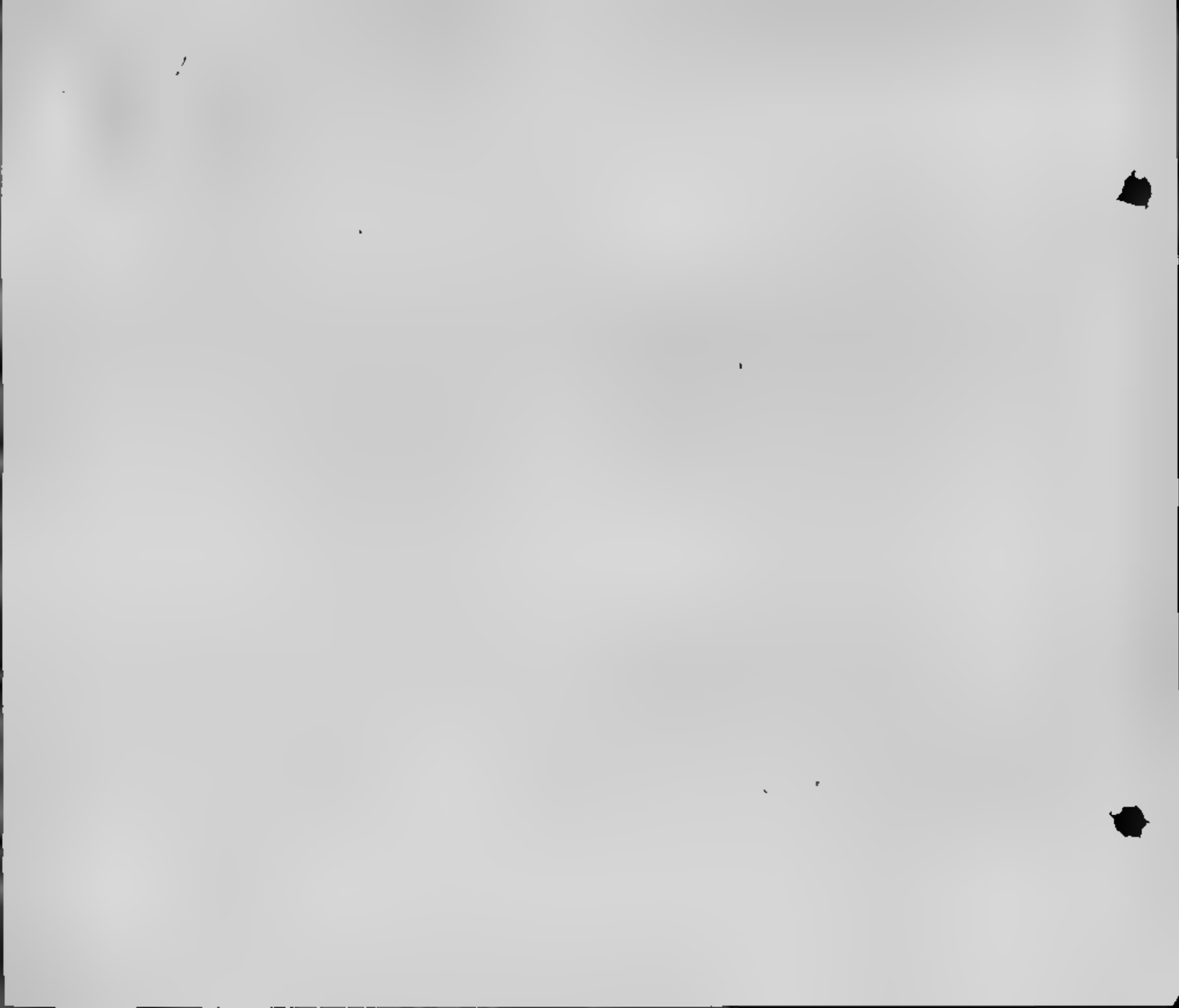
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04436
REF. DIS.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>—</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Middle River</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore 29.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wm. H. Martin Co.</u>		STREET ADDRESS (If rural, give location) <u>3714 Clarendon Rd.</u>	
3. NAME OF DECEASED (First, Middle, Last) <u>Melvin S. Rice</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 9 1965</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Nov 11/1902</u>
9. AGE last birthday. <u>52</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Port Washington N.Y.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>?</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W. 1+2</u>		16. SOCIAL SECURITY No.: <u>7-1-2</u>	
17. INFORMANT & ADDRESS: <u>Vera V. Rice 3714 Clarendon Rd.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u> DUE TO		<u>2030 hrs</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>May 9 1965</u>		19b. MAJOR FINDING OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home farm, factory, street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21e. TIME (Month) (Day) (Year) (Hour) <u>May 9 1965 3:30 PM</u>		21f. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from, Natura. causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
SIGNATURE <u>Melvin S. Rice</u>		M. D. <u>Dr. D.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>5/11/55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Balto National</u>		LOCATION (City town or county) (State): <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: <u>DR. D.</u>		FEDERAL DIRECTOR'S SIGNATURE: <u>DR. D.</u>	
FEE: <u>10-35</u>		ADDRESS: <u>3615 117</u>	



04437

MARYLAND

4452

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Id.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>52 Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town, OR TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3 21 Lambeth Rd</u>		STREET ADDRESS (If rural, give location, <u>321 Lambeth Rd</u>	
3. NAME OF DECEASED (First, Middle, Last) <u>George L. Richter</u>		4. DATE OF DEATH (Month, Day, Year) <u>May 5/55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 7, 1882</u>
9. AGE last birthday <u>73</u> yrs.		10. BIRTHPLACE (state or foreign country) <u>Balto. Md.</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Installation</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S.P. Telephone Co.</u>	
13. FATHER'S NAME <u>John O. Richter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thesing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If year, give was in service) <u>yes</u>		16. Social Security No. <u>12 05 0591</u>	
17. INFORMANT AND ADDRESS <u>Miss Jessie V. Richter, 321 Lambeth Rd</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Coronary Thrombosis</u>				<u>1 hr.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Ch. Nephritis & Ch. Valvular heart</u> <u>Arterio Sclerosis</u>				<u>10 yrs</u> <u>10 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11-17, 1950, to 5-5-55, 1955, that I last saw the deceased alive on 5-3-55, 1955, and that death occurred at 3:30 A. M., from the causes and on the date stated above.

SIGNATURE <u>Geo. A. Ellis</u>		ADDRESS <u>4100 Edmondson Ave 28 Balto. Md.</u>		DATE SIGNED <u>5/5/55</u>	
23. BURIAL, CREMATION, or other disposal (Specify) <u>Buried</u>		DATE <u>May 7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Pl.</u>	
DATE REC'D BY LOCAL REG. <u>6 6 55</u>		REGISTRAR'S SIGNATURE <u>Wm. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Harrold H. H. H.</u>	
				ADDRESS <u>4101 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING



4453

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

43

1 PLACE OF DEATH COUNTY <u>Balto</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Raspbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Raspbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>206 Elinor Ave</u>		STREET ADDRESS (If rural, give location) <u>206 Elinor Ave</u>	
3 NAME OF DECEASED (Type or Print) <u>James B. Riley</u>		4 DATE OF DEATH (Month) <u>5</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 5, 1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	9. AGE last birthday <u>33</u> yrs. If under 1 year: Months <u>0</u> Days <u>25</u> Hours <u>0</u> Min <u>0</u>
11. BIRTHPLACE (State or foreign country) <u>Hartford Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. Frank Riley</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda M. Chewworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War II</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	
17. INFORMANT AND ADDRESS <u>Mrs Rhoda Chewworth Riley and</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Coronary Occlusion</u>			
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Hypertension (Arterio Vascular Disease)</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE Home, farm, factory street, or other indg., etc.) <u>INDUSTRY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above held an Autopsy Inspection Inquiry Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE <u>J. J. [illegible]</u>		DATE SIGNED <u>5/28/55</u>	
23. BURIAL CREMATION (If removal, specify)	DATE THEREOF <u>5/28/55</u>	NAME OF CEMETERY OR CREMATORY <u>St Johns Cath</u>	LOCATION City, town, or county (State) <u>Balto. Co md</u>
DATE RECEIVED BY LOCAL REG	REGISTRAR'S SIGNATURE <u>May 28 '55 Mrs M. T. [illegible]</u>	24. FUNERAL DIRECTOR ADDRESS <u>Lassalle Funeral Home 7401 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

04439

4454

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>24</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7517 Lange Avenue</u>		STREET ADDRESS (If rural, give location) <u>7517 Lange Avenue</u>	
3. NAME OF DECEASED (First) <u>Charles</u> (Middle) <u>Kaene</u> (Last)		4. DATE OF DEATH Month, (Day) (Year) <u>May 22</u> 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 26, 1874</u>
9. AGE last birthday <u>80</u> yrs. <u>80</u> months <u>22</u> days <u>22</u> hours <u>22</u> min.		10. BIRTHPLACE State or foreign country <u>Baltimore</u>	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Laborer - Retired</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Raabe</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>212-01-67799</u>	
17. INFORMANT AND ADDRESS <u>Raymond C. Raabe - 7517 Lange Ave.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
-31X Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>4 hours</u>	
Antecedent cause(s) (b) <u>Hypertension - Brady Cardia</u>		<u>1 year</u>	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause, last (c) <u>Arterio-Sclerosis</u>		<u>2</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Hypertrophied Prostate</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 10, 1954</u> , to <u>May 22, 1955</u> , that I last saw the deceased alive on <u>May 22, 1955</u> , and that death occurred at <u>11 55 a m.</u> , from the causes and on the date stated above			
SIGNATURE <u>Morris G. Jacobs M.D.</u>		ADDRESS <u>1010 North St Rt. 24 Baltimore</u>	
DATE SIGNED <u>5/23/55</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>May 25 1955</u>		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>5-25-55</u>		REGISTRAR'S SIGNATURE <u>R. W. Heald</u>	
FURNAL DIRECTOR <u>John C. Muller</u>		ADDRESS <u>2431 E. Oliver St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians - please write the causes of death clearly and legibly.



4455

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
TOWN 5 Months		TOWN 2001-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House of The Pines Rusting Ave		STREET ADDRESS (If rural, give location) 6104 Pimlico Road	
3. NAME OF DECEASED (Type or Print) Lucy Jane Rickerd		4. DATE OF DEATH (Month, Day, Year) May 30 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 3-25-1875
9. AGE last birthday 80 yrs.		10. UNDER 1 year 2 Moths	11. UNDER 24 hrs 5 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Olive Township, Michigan		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William Webb		14. MOTHER'S MAIDEN NAME Lucy M. Carpenter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT Mrs Dorothy Newman, 6104 Pimlico Rd.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
447X Immediate cause (a) Hypertension - Essential Antecedent cause(s) (b) Atherosclerosis Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> m. Work <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/20 , 19 55 , to 5/30 , 19 55 , that I last saw the deceased alive on 5/30 , 19 55 , and that death occurred at 10¹⁵A m., from the causes and on the date stated above.			
SIGNATURE Lawrence J. Schwartz M.D.		ADDRESS 2324 Eutaw Place	
DATE SIGNED 5/31/55			
23. BURIAL, CREMATION, or other disposal (Specify) Removal		DATE THEREOF 6-2-55	
NAME OF CEMETERY OR CREMATORY Crystal Cemetery		LOCATION (City, town, or county) (State) Michigan	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG.		24. FUNERAL DIRECTOR David R. Martin, 1902 Eutaw Place	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians' please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4456

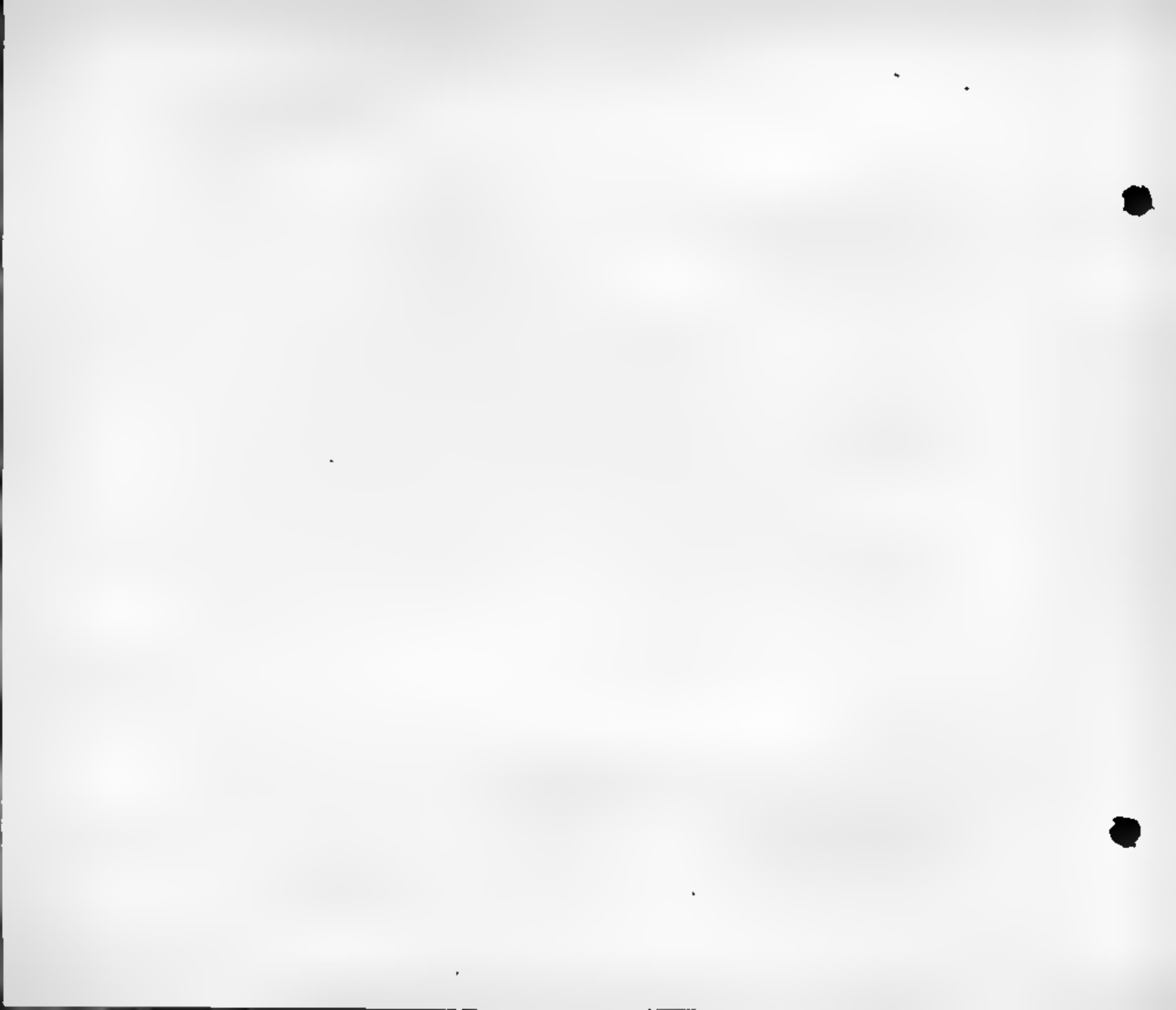
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04441

CERTIFICATE OF DEATH

Reg. Dist. No. 604

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> CITY If not de corporate limits write RURAL LENGTH OF STAY (in this place) OR and nearest town TOWN <u>Fort Howard</u> <u>1 day</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STATE <u>Maryland</u> COUNTY CITY If outside corporate limits write RURAL and give nearest town OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>2427 Kermit Court</u>	
3 NAME OF DECEASED (Type or Print)		4 DATE (Month) Day (Year)	
First (Middle) Last <u>WILLIAM R. ROCKEL</u>		OF DEATH <u>May 10 19 55</u>	
5 SEX 6 CO OR OR 7 SINGLE MARRIED B DATE OF BIRTH 9 AGE last birthday 10 UNDER 1 YEAR 11 UNDER 14 MRS Months Days Hours Min			
Male White Widowed Divorced Married <u>5/30/90</u> Race Specify			
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B KIND OF BUSINESS OR INDUSTRY	
<u>Surveyor</u>		<u>Construction</u>	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
<u>George Rockel</u>		<u>Catherine Tantz</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If Yes, give war or dates of service		16 SOCIAL SECURITY NO	
<u>Yes WW I</u>		<u>213-14-2873</u>	
17 INFORMANT & ADDRESS			
<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18 MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>MITRAL INSUFFICIENCY</u> ANTECEDENT CAUSE (B) <u>CHRONIC RHEUMATIC ENDOCARDITIS</u>		UNKNOWN UNKNOWN	
D SEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B PLACE Home farm factory street, office bldg., etc.	
		21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While at work Not while at work	
		21F HOW DID INJURY OCCUR?	
22 I hereby certify that I attended the deceased from <u>May 9 19 55</u> to <u>May 10 19 55</u> and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above			
SIGNATURE <u>WILLIAM B. VANDEKRIFT, M.D.</u>		ADDRESS <u>VAH, FORT HOWARD, MD.</u> DATE SIGNED <u>5-12-55</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) DATE THEREOF		NAME OF CEMETERY OR CREMATORY LOCATION (City or town or county) State	
<u>Burial</u> <u>5/13/55</u>		<u>Baltimore National</u> <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		24 FUNERAL DIRECTOR ADDRESS	
<u>12-55</u> <u>W. Hedge</u>		<u>Wm. Cook-Blight, Inc. Funeral Home</u> <u>Baltimore 11, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

04443

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

4457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Riderwood		CITY (If outside corporate limits, write RURAL and give nearest town) Riderwood	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1901 Old Court		STREET ADDRESS (If rural, give location) 1901 Old Court Road	
3. NAME OF DECEASED (Type or Print) Ruth Elizabeth Roller	4. DATE OF DEATH (Month) (Day) (Year) May 5, 1955		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Sept. 23, 1938
9. AGE last birthday 16 yrs.	10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired Student	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY U.S.
13. FATHER'S NAME Vernon Roy Roller		14. MOTHER'S MAIDEN NAME Louise Startt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY No.	
17. INFORMANT Vernon R. Roller 1901 Old Court Rd. Riderwood			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 197X Immediate cause (a) Liposarcoma of pelvis Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 2/21/55	19b. MAJOR FINDINGS OF OPERATION Suppurative Liposarcoma		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/29, 1955 , to 5/5, 1955 , that I last saw the deceased alive on 5/4, 1955 , and that death occurred at 2:45 p.m. , from the causes and on the date stated above.			
SIGNATURE Bennett A. Steers		DATE SIGNED 5/6/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 8, 1955	NAME OF CEMETERY OR CREMATORY Falls Road Methodist
DATE REC'D BY LOCAL REG. 5-6-55		REGISTRAR'S SIGNATURE John C. Mitchell	24. FUNERAL DIRECTOR John C. Mitchell & Sons Inc.
		LOCATION (City, town, or county) Baltimore, Co.	
		ADDRESS 1900 Eutaw Place	



4458

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04442

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 13 14 Film 6181 6-18-44 st

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balt. Cty</u>	
CITY (If outside corporate limits, write RURAL, and OR give nearest town) <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>20 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balt. Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>375 L. St.</u>	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>May 13 1955</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>1, 1932</u>		9. AGE last birthday <u>23</u> yrs.		10. If under 1 year Months Days If under 24 hrs Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Miss. getts</u>	
12. FATHER'S NAME <u>-- Neiss</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Balt. 10 rs. Margaret Chat 905 Westminster St</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
351X Immediate cause (a) <u>Cerebrovascular accident</u>					<u>Minutes</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>					<u>16 hr.</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not White At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-26</u> , 19 <u>55</u> , to <u>5-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>55</u> and that death occurred at <u>10:00 A</u> m., from the causes and on the date stated above					
SIGNATURE		(Degree or title)		ADDRESS DATE SIGNED	
23. BURIAL, CREMATION, OR OTHER (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>May 16, 1955</u>		<u>Woodlawn Cemetery</u>	
24. FUNERAL DIRECTOR		ADDRESS		DATE	
<u>Raymond J. Curran</u>		<u>710 N. Charles St.</u>		<u>May 15, 1955</u>	

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4459

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04444

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 PLACE OF DEATH.

COUNTY BALTO. MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) EDGEWATER (19) 9 YRS
 TOWN EDGEWATER (19)
 HOSPITAL OR MILLER ISLAND RD.
 INSTITUTION OR P.O. BOX #29
 STREET ADDRESS

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE MD. COUNTY BALTO
 CITY (If outside corporate limits write RURAL and give nearest town) EDGEWATER (19)
 TOWN EDGEWATER (19)
 STREET ADDRESS PO BOX #29

3 NAME OF DECEASED (Type or Print)

(First) ALEXANDER (Middle) JOHN (Last) ROZWADOWSKI

4 DATE OF DEATH

(Month) 5 (Day) 8 (Year) 1955

5. SEX:

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED.

8. DATE OF BIRTH

9. AGE last birthday (If under 1 year, 1 year, 2 years, 3 years, 4 years, 5 years, 6 years, 7 years, 8 years, 9 years, 10 years, 11 years, 12 years, 13 years, 14 years, 15 years, 16 years, 17 years, 18 years, 19 years, 20 years, 21 years, 22 years, 23 years, 24 years, 25 years, 26 years, 27 years, 28 years, 29 years, 30 years, 31 years, 32 years, 33 years, 34 years, 35 years, 36 years, 37 years, 38 years, 39 years, 40 years, 41 years, 42 years, 43 years, 44 years, 45 years, 46 years, 47 years, 48 years, 49 years, 50 years, 51 years, 52 years, 53 years, 54 years, 55 years, 56 years, 57 years, 58 years, 59 years, 60 years, 61 years, 62 years, 63 years, 64 years, 65 years, 66 years, 67 years, 68 years, 69 years, 70 years, 71 years, 72 years, 73 years, 74 years, 75 years, 76 years, 77 years, 78 years, 79 years, 80 years, 81 years, 82 years, 83 years, 84 years, 85 years, 86 years, 87 years, 88 years, 89 years, 90 years, 91 years, 92 years, 93 years, 94 years, 95 years, 96 years, 97 years, 98 years, 99 years, 100 years)

10a. USUAL OCCUPATION Give kind of work done during most of working life, (Specify if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME:

UNKNOWN

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-07-8733

17. INFORMANT & ADDRESS.

ANNA R. ROZWADOWSKI - SAME

18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

204.1

Immediate cause

(a)

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

19. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. ACCIDENT SUICIDE HOMICIDE

Specify

PLACE Home, farm, factory street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 17, 1955 to May 8, 1955, that I last saw the deceased

alive on May 8, 1955, and that death occurred at 11:00 AM, from the causes and on the date stated above

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. RITUAL CREMATION, DATE THEREOF

15-11-55

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town & county)

(State)

24. FUNERAL DIRECTOR

NAME OF FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

REGISTRAR

May 10-55 Dawson L. Harbor

White Birch Lodge, Parkville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are & especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

4460

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04445

Item 9, Film G183, 6/30/55

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Typo.</u> OR <u>CATONSVILLE</u> TOWN <u>Spring Grove State Hospital</u> HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Hospital</u>				STATE <u>Md.</u> COUNTY <u>Balto. City</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>3114</u> OR <u>1078 W. Thompson Ave</u> TOWN <u>1078 W. Thompson Ave</u> STREET ADDRESS (If rural give location)			
3 NAME OF DECEASED (Type or Print) <u>EMMA M. SAMUELS</u>				4 DATE (Month) (Day) (Year) OF DEATH <u>5-19-1955</u>			
5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u> 7 SINGLE MARRIED WIDOWED DIVORCED <u>W</u> 8 DATE OF BIRTH <u>6-1881</u> 9 AGE at birth <u>73</u> IF UNDER 1 YEAR IF AGED 1 YEAR Months Days Hours Min				10 A. USUAL OCCUPATION (Give kind of long most of working life) <u>Saleswoman</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u> 10C. PLACE (State or foreign country) <u>Maryland</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13 FATHER'S NAME <u>Thomas Bibson</u>				14 MOTHER'S MAIDEN NAME <u>Margaret Ann Thomas</u>			
15. MEDICAL CERTIFICATION				17 INFORMANT'S ADDRESS <u>SON 1719 N. UNION AVE.</u>			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				CRIMINAL RECORD ONSET AND DATE			
IMMEDIATE CAUSE <u>421.)</u> ANTECEDENT CAUSE IS <u>Interosclerotic heart disease</u> DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <u>Generalized arteriosclerosis</u> <u>Senility and Debility</u>				(A) DUE TO <u>years</u> (B) DUE TO <u>years</u> (C) <u>years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A DATE OF OPERATION				19B MAJOR FINDINGS OF OPERATION			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)				21B PLACE (Home, farm, factory, street, office bldg., etc.)			
21C TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21D WHERE DID INJURY OCCUR? (City or town) (County) (State)				21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-19-1955</u> to <u>5-19-1955</u> , that I last saw the deceased alive on <u>5-19-1955</u> , and that death occurred at <u>7:45 PM</u> from the causes and on the date stated above							
SIGNATURE <u>S. Wachler</u>				DATE SIGNED <u>5-19-55</u>			
23 BURIAL CREMATION REMOVAL (Specify)				NAME OF CEMETERY OR CREMATIONATION PLANT <u>Spring Grove State Hosp.</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>5-20-55</u>				REGISTRAR'S SIGNATURE <u>C. W. Hedgcock</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>5-20-55</u>				ADDRESS <u>1078 W. Thompson Ave</u>			

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4461

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY If outside corporate limits write RURAL and give nearest town	LENGTH OF STAY (in this place)	CITY If outside corporate limits write RURAL and give nearest town	
OR	77 days	OR	
TOWN FORT HOWARD		TOWN BALTIMORE	311
HOSPITAL OR INST TLT ON OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
VETERANS ADMINISTRATION HOSPITAL		407 PATAPSCO AVENUE	
3 NAME OF DECEASED (Type or Print)	First (Middle)	Last	4 DATE (Month) (Day) (Year)
FREDERICK J. SCHREIBER			MAY 8 1955
5 SEX	6 COLOR OR RACE	7 SINGLE MARRIED	8 DATE OF BIRTH
MALE	WHITE	WIDOWED	6-30-78
9 AGE last birthday	10 MONTHS	11 DAYS	12 HOURS
76			
10A USUAL OCCUPATION (Give kind of work then doing the day of death even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
LABORER	BRICK YARD	BALTIMORE, MARYLAND	U.S.A.
13 FATHER'S NAME	14 MOTHER'S M A DEN NAME	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16 SOCIAL SECURITY NO
FERDINAND SCHREIBER	BARBARA BECK	YES	UNKNOWN
17 INFORMANT'S ADDRESS	18 MEDICAL CERTIFICATION	19 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.		570.5	
		IMMEDIATE CAUSE	(A) INTESTINAL OBSTRUCTION, LOWER ILLUM
		ANTECEDENT CAUSE (B)	24 HOURS
		DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	(B) ADHESIVE BAND
			UNKNOWN
		20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	(C) 1. ARTERIOSCLEROTIC HEART DISEASE
			2. DIABETES MELLITUS
19A DATE OF OPERATION	19B MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5-7-55	INTESTINAL OBSTRUCTION DUE TO ADHESIVE BAND		
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21B PLACE (Home, farm, factory, street, office, body, etc.)	21C WHERE D.D. (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED (While at work) (Not while at work)	21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 20, 1955 to May 8, 1955 , and that death occurred at 10:30 AM from the causes and on the date stated above.			
SIGNATURE IRVING FREEMAN, M.D.		DATE SIGNED 5-8-55	
23 BURIAL CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY LOCATION (City or town or county) (State)	
Burial		Baltimore National Cemetery Baltimore, Maryland	
DATE RECD BY LOCAL REGISTRAR		24 FUNERAL DIRECTOR ADDRESS	
May 11, 1955		J. U. CORNELLY FUNERAL HOME	
REGISTRAR'S SIGNATURE		418 Eastern Ave., Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4462

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, filed 191 5-12-55 at

CERTIFICATE OF DEATH

Reg. Dist. No.

044470

1. PLACE OF DEATH

COUNTY Balto. MARYLAND
CITY Catonsville RURAL LENGTH OF STAY
OR Catonsville (in this place)
TOWN

HOSPITAL OR Catonsville Convalescent Home
INSTITUTION OR Ingleside & Edmondson Aves.
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY Balto.
CITY If outside corporate limits write RURAL and give nearest town)
OR Catonsville Baltimore
TOWN Catonsville 3V14
STREET Catonsville Nursing Home
ADDRESS Ingleside and Edmondson Ave.
2036 N. North Ave.

3. NAME OF DECEASED (Type or Print)

FIRST (Middle (Last)
SUSAN PRUDENCE SCHROEDER

4. DATE OF DEATH Month (Day) (Year)
May 8, 1955

5. SEX

6. COLOR OR 7. SINGLE MARRIED. 8. DATE OF BIRTH

9. AGE last birthday 10. UNDER 1 YEAR 11. UNDER 18 HAD Months Days Hours Min
85 May 8, 1869

10A. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH-PLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
Maryland

13. FATHER'S NAME

Richard Ford Schroeder

14. MOTHER'S MAIDEN NAME

Anne Elizabeth Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Rev. J. H. Braunlein-405 Normandy Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) DUE TO

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

Coronary Thrombosis
Arterio-sclerotic Cardiovascular Disease
Senility

INTERVAL BETWEEN ONSET AND DEATH
Indefinite
10 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

No operation

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
IF EITHER NOTIFY MEDICAL EXAMINER

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)

21C. WHERE DID (City or town) (County) (State)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 31, 1950 to May 8, 1955, that I last saw the deceased

alive on May 8, 1955, and that death occurred at 11:30 P.M. from the causes and on the date stated above

SIGNATURE

Joel H. Armacost

ADDRESS 6419 Windsor Mill Rd Baltimore

DATE SIGNED 5-10-55

23. BY RURAL CREMATION REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City or town or county)

State

Burial

5/12/55

Lorraine Park Cem.

Woodlawn, Md.

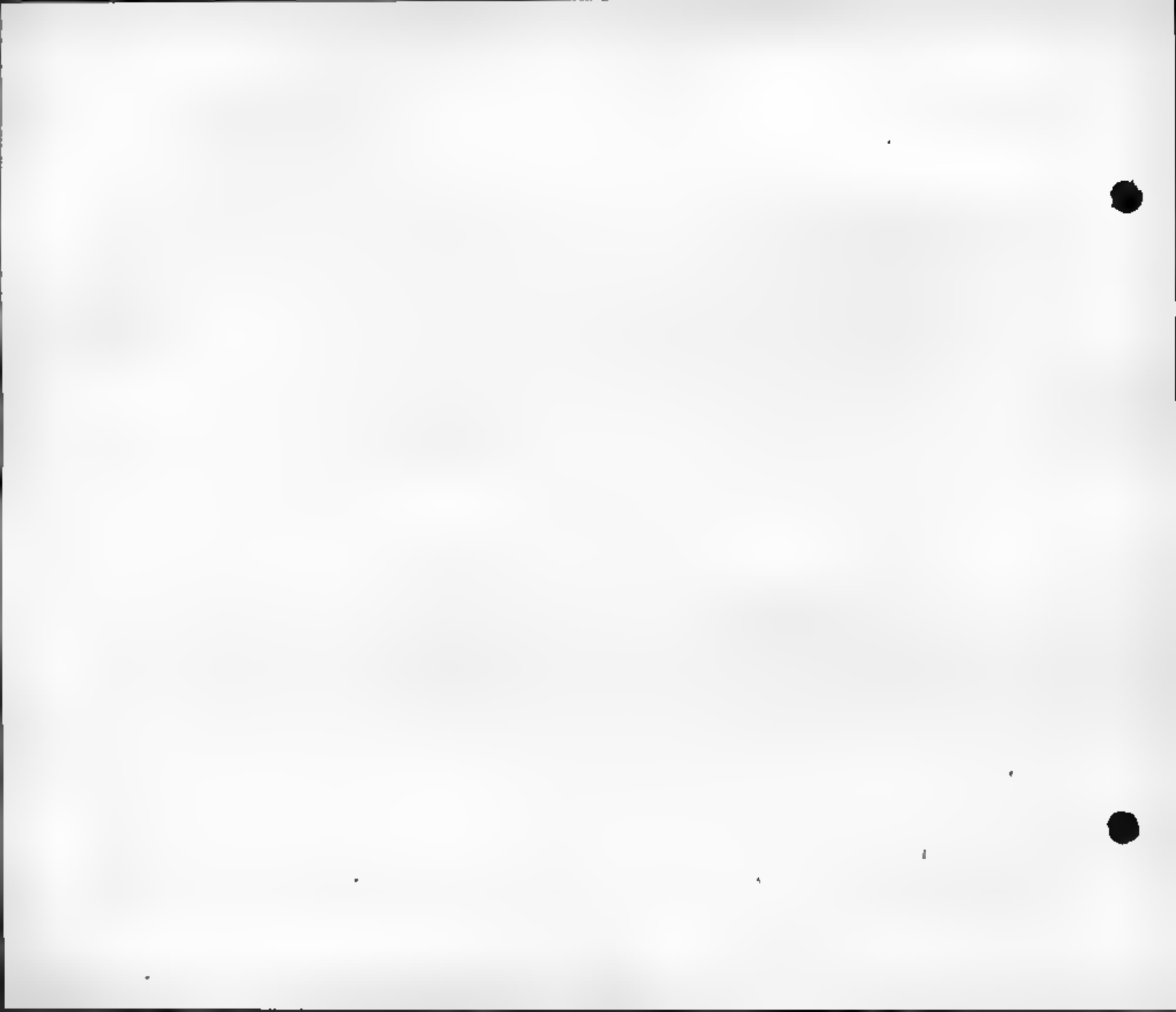
DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

100-55 Rev. J. H. Braunlein 405 Normandy Ave.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4463

CERTIFICATE OF DEATH

04448
Reg. Dist. No. 30

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY <u>Baltimore</u> OR TOWN <u>Catonville</u> LENGTH OF STAY <u>12 mos. 5 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY <u>Fallston</u> OR TOWN <u>Fallston</u> STREET ADDRESS <u>12X-2</u>	
3 NAME OF DECEASED <u>Mattie A. Sexton</u> (Type or Print)		4 DATE (Month) (Day) (Year) OF DEATH <u>May 16, 1955</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-2-1896</u>
9 AGE last birthday <u>58</u> yrs. Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min.		10A USUAL OCCUPATION (give kind of work done during most of working life even if retired) <u>Factory work</u>	
10B KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13 FATHER'S NAME <u>Unknown</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17 INFORMANT'S ADDRESS <u>Accresis Spring Grove State Hospital</u>		18 MEDICAL CERTIFICATION	
19 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Terminal bile ex. pneumonia</u>		<u>3 day</u>	
(B) ANTECEDENT CAUSE (8) <u>Inanition and anoxia</u>		<u>weeks</u>	
(C) DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST <u>Acute senile brain disease</u>		<u>2 months</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION <u>3-11-1955</u>		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory) OF INJURY <u>street office bldg.</u>	
21C WHERE D.D. (City or town) (County) (State) <u>Fallston Harford Maryland</u>		21D HOW DID INJURY OCCUR?	
21E TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 16, 1955</u>		21F INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> <u>At work</u> <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>3-11-1955</u> to <u>5-16-1955</u> , that I last saw the deceased alive on <u>5-16-1955</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		DATE SIGNED <u>5-17-55</u>	
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>May 17, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Grove State Hospital</u>		LOCATION <u>Harford, Md.</u>	
DATE RECD BY LOCAL REGISTRAR <u>5/17/55</u>		REGISTRAR'S SIGNATURE <u>D.E. Harvey</u>	
24 FUNERAL DIRECTOR <u>Wm. H. Green</u>		ADDRESS <u>Harford, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No. 4

4338

1 PLACE OF DEATH.

COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL, and give nearest town) Dundalk
OR and give nearest town
HOSPITAL OR INSTITUTION OR STREET ADDRESS 259 Colgate Ave.

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY 7
CITY (If outside corporate limit, write RURAL, and give nearest town) Dundalk
OR
TOWN
STREET ADDRESS 259 Colgate Ave. If data give location

3 NAME OF DECEASED.
(Type or Print)

First, HARRY

Middle, S.

(Last) SHEALEY

4 DATE OF DEATH

(Month) May 13

(Day)

(Year) 1955

5 SEX

Male

6 COLOR OR RACE

White

7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8 DATE OF BIRTH.

March 27, 1872

9 AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months, Days Hours Min

83 yrs.

10a USUAL OCCUPATION Give kind of work done during most of working life, even if retired, Engineer

10b KIND OF BUSINESS OR INDUSTRY Construction

11 BIRTHPLACE (State or foreign country) Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME:

Henry Shoaley

14 MOTHER'S MAIDEN NAME:

Mary A. Shock

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

16 SOCIAL SECURITY No.:

17 INFORMANT & ADDRESS.

Mrs. Lucille Kellner Apt. A 1, Dunleer Apts.

18 MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

152 X

Immediate cause

(a) DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

CAVCMATOSIS
Carcinoma Small Intestines

Interval Between Onset And Death

6 months

2 yrs

19 OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION.

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1944 to May 13, 1955, that I last saw the deceased

alive on May 10, 1955, and that death occurred at 9 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. REMOVAL (Specify)

Buried

DATE THEREOF

May 16, 1955

NAME OF CEMETERY OR CREMATORY

Oak Lawn

LOCATION (City, town, or county)

Colgate Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

May 15 1955

William M. Tully

24 FUNERAL DIRECTOR

Ullrich Funeral Home 2112 Dundalk Ave.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are especially important. Please write the causes of death clearly and legibly.

1

BUREAU W. O.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

4464

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04450

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Ma.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparks (Rural)</u>	LENGTH OF STAY (in this place) <u>3 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparks (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd</u>		STREET ADDRESS (If rural give location) <u>York Rd.</u>	
3 NAME OF DECEASED (First) (Middle) (Last)		4 DATE (Month) (Day) (Year)	
<u>Howard Eugene Shelley</u>		OF DEATH <u>May 2 1955</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. SINGLE MARRIED <u>married</u>	8 DATE OF BIRTH <u>Feb. 17, 1884</u>
9 AGE (last birthday) <u>70</u> yrs		10 AGE (last birthday) <u>70</u> yrs	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Joshua Shelley</u>		14 MOTHER'S MAIDEN NAME <u>Rebecca J. Hackett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16 SOCIAL SECURITY NO. <u></u>	
17 INFORMANT'S ADDRESS <u>Mrs. Alice F. Shelley, Sparks, Md.</u>		18 MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>		3 hrs.	
ANTECEDENT CAUSE (B) <u></u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21B PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F HOW DID INJURY OCCUR?	
22 I hereby certify that I attended the deceased from <u>May 2, 1955</u> , to <u>May 2, 1955</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above			
SIGNATURE <u>A. M. France</u>		DATE SIGNED <u>5/3/55</u>	
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Freeland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 19 1955</u>		24 FUNERAL DIRECTOR <u>Brookland Funeral Home, Sparks, Md.</u>	

1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04451

4465

CERTIFICATE OF DEATH

Reg. Dist. No. 31014

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (if a trade or corporate limit write RURAL and give nearest town) OR <u>TOWN</u> <u>FORT HOWARD</u> HOSPITAL OR INSTITUTE OR ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY CITY (if outside corporate limits write RURAL and give nearest town) OR <u>TOWN</u> <u>BALTIMORE</u> STREET ADDRESS (if rural give location) <u>201 S. ANN STREET</u>	
3 NAME OF DECEASED (Type or Print)		4 DATE (Month, Day, Year) OF DEATH	
First (Last) (Middle) (Last) <u>WALTER P SHERBA</u>		<u>MAY 2 1955</u>	
5 SEX 6 COLOR OR RACE 7 SINGLE MARRIED WIDOWED DIVORCED (Specify)		8 DATE OF BIRTH 9 AGE last birthday IF UNDER 1 YEAR IF OVER 1 YEAR	
<u>MALE</u> <u>WHITE</u> <u>SINGLE</u>		<u>6/28/21</u> <u>33</u> yrs	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10B KIND OF BUSINESS OR INDUSTRY	
<u>Store Work</u>		<u>STORE</u>	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
<u>BALTIMORE, MARYLAND</u>		<u>U.S.A.</u>	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
<u>ALEXANDER SHERBA</u>		<u>MARY LIPPS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) If yes, give war or date of service		16 SOCIAL SECURITY NO	
<u>YES</u> <u>WW-II</u>		<u>UNKNOWN</u>	
17 INFORMANT & ADDRESS		18 MEDICAL CERTIFICATION	
<u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>		18. MEDICAL CERTIFICATION 19. MEDICAL CERTIFICATION	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>2041</u>		<u>2 MONTHS</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(A) <u>MYELOID LEUKEMIA, ACUTE</u> DUE TO (B) DUE TO (C)	
21 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
<u>AGNOGENIC MYELOID METAPLASIA</u>			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
<u>1/11/55</u>		<u>SPLENECTOMY * AGNOGENIC MYELOID METAPLASIA</u>	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory, etc.) OF INJURY	
<input type="checkbox"/>		<input type="checkbox"/>	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D TIME (Month Day) (Year) (Hour) OF INJURY	
<u>VA</u>		<u>VA</u>	
21E INJURY OCCURRED While at work Not while at work		21F HOW DID INJURY OCCUR?	
<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from Nov. 21, 1954 to May 2, 1955, and that death occurred at 2:00 P M from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Francis G. Dickey, M.D.</u>		<u>5/2/55</u>	
23 BURIAL CREMATION DATE THEREOF		NAME OF CEMETERY OR CREMATORY LOCATION (City or town, or county) (State)	
<u>BURIAL</u>		<u>HOLY ROSARY CEMETERY</u> <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		24 FUNERAL DIRECTOR ADDRESS	
<u>5/3/55</u>		<u>FRED W. OZAZEWSKI FUNERAL HOME</u> <u>1930 EASTERN AVE. BALTIMORE, MD.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4466

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04452

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1 PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND CITY <u>Lutherville</u> (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lutherville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>		2 USUAL RES DENCE HOME OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lutherville</u> STREET ADDRESS (If rural give location) <u>1</u>	
3 NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>SHIELDS</u> (Last) 4 DATE OF DEATH <u>May</u> 18 19 <u>55</u>		5 SEX <u>female</u> 6 COLOR OR RACE <u>white</u> 7 SINGLE MARRIED WIDOWED <u>WIDOWED</u> 8 DATE OF BIRTH <u>Jan. 10, 1865</u> 9 AGE (last birthday) <u>90</u> yrs. <u>18</u> months <u>1</u> days <u>1</u> hours <u>1</u> min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10B KIND OF BUSINESS OR INDUSTRY <u>at home</u> 11 BIRTHPLACE (State or foreign country) <u>Penna.</u> 12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME <u>John Lewis</u> 14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, by unk.) <u>no</u> (If Yes, give war or dates of service) 16 SOCIAL SECURITY NO. <u>none</u> 17 INFORMANT & ADDRESS <u>YORK Mrs. Robert Clarkson-550 Park Ave., New /</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>3x</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE (B) <u>Hypertensive Cardio-Vascular Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	
19A DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21B PLACE (Home, farm, factory or INJURY street, office bldg., etc) 21C WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u> 21E INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March</u> 19 <u>55</u> , to <u>MAY</u> , 19 <u>55</u> that I last saw the deceased alive on <u>5/18</u> , 19 <u>55</u> , and that death occurred at <u>4:40</u> PM, from the causes and on the date stated above. SIGNATURE <u>M. Quinn</u> ADDRESS <u>TIMONIUM</u> DATE SIGNED <u>5/19/55</u>			
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>5/20/55</u> NAME OF CEMETERY OR CREMATORY <u>Church of Redeemer</u> LOCATION City town, or county, State <u>Brown Mawr, Pa.</u>		DATE REC'D BY LOCAL REGISTRAR <u>5-20-55</u> REGISTRAR'S SIGNATURE <u>a w. [signature]</u> FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. [signature]</u> ADDRESS <u>[signature] Balt. 17</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4467 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04453
 Reg. Dist.

No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write OR and give nearest town) <u>Rural</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Victory Villa</u>			
TOWN <u>U.S. 90 Highway</u>				STREET ADDRESS (If rural, give location) <u>3 Kelly Road Baltimore 20</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (First) <u>Hugh</u> (Middle) <u>D</u> (Last) <u>Shuffler</u>				DATE OF DEATH (Month) <u>5</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX. <u>M</u>		6. COLOR OR RACE. <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Jan. 1, 1934</u>	
9. AGE last birthday: <u>21</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country): <u>Mitchell Co. N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Carrick N. Shuffler</u>				14. MOTHER'S MAIDEN NAME: <u>Sally E. Garland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or rank) <u>No</u> If Yes, give war or dates of service				16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Mr. Carrick N. Shuffler, 3 Kelly Rd. Victory Villa</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.							
<p>929.8 Immediate cause (a) <u>Asphyxiation</u> DUE TO</p> <p>Antecedent cause(s) (b) <u>Drowning</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u></u>				19b. MAJOR FINDING OF OPERATION: <u></u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Rural</u>		21c. (City or town, (County) <u>Baltimore County</u> (State) <u>Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 29 55 PM</u>				21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Drown while swimming</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <u>William Updell</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-30-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>5-30-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Presbyterian Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Co. N. C.</u>	
DATE REC'D BY LOCAL REG. <u>June 2, 1955</u>		REGISTRAR'S SIGNATURE: <u>Carth. Hurley</u>		24. FUNERAL DIRECTOR: <u>LaSalle Funeral Home</u>		ADDRESS: <u>7101 Belair Rd.</u>	

3

1

4468

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04454

CERTIFICATE OF DEATH

Item 17, Film 181 5-19-55 8

Reg. Dist. No. *XX*

1 PLACE OF DEATH

COUNTY BALTIMORE

CITY (If outside corporate limits write RURAL, OR and give nearest town)

TOWN FORT HOWARD

MARYLAND

LENGTH OF STAY (in this place)

1 HR. 530 Min.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

VETERANS ADMINISTRATION HOSPITAL

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN BALTIMORE

STREET ADDRESS

(If rural give location)

2938 ELLIOTT STREET

3 NAME OF DECEASED (Type or Print)

(First)

RAYMOND

(Middle)

J.

(Last)

SKOTARSKI

4 DATE (Month)

(Day)

(Year)

OF

DEATH

MAY

11

1955

5 SEX

6 CO OR OR 7

SINGLE

MARRIED

8 DATE OF BIRTH

WIDOWED

DIVORCED

9 AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN

MALE

WHITE

1

(Specify)

SINGLE

8-17-20

34

10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

BARTENDER

10B KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12 CITIZEN OF WHAT COUNTRY?

U. S. A.

13 FATHER'S NAME

JOHN SKOTARSKI

14 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) If Yes, give war or dates of service

YES

WW II

15 SOCIAL SECURITY NO

218-07-5388

16 INFORMANT & ADDRESS
KATHERINE MN: UNKNOWN
Clin. Rec., Vet. Adm., Ft. Howard, Md.

17 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

5810

IMMEDIATE CAUSE

A) CIRRHOSIS OF LIVER WITH SEVERE FATTY

CHANGE

INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

DUE TO

(C)

18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY?

YES ☒ NO ☐

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER

21B PLACE Home farm factory OF INJURY street, office bldg

21C WHERE D.D. City or town) (County) (State)

INJURY OCCUR?

21D TIME (Month Day) Year) (Hour) OF INJURY

VA

21E INJURY OCCURRED While at work Not while at work

21F HOW DID INJURY OCCUR?

3:00 P.M.

4:50 P.M.

22. I hereby certify that I attended the deceased from MAY 11, 1955 to MAY 11, 1955 that death occurred at 3:00 P.M. from the causes and on the date stated above

SIGNATURE

WILLIAM B. VANDEGRIFT, M.D.

ADDRESS

DATE SIGNED

M.D. VAH, FORT HOWARD, MARYLAND 5-12-55

23 BURIAL CREMATION DATE THEREOF REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county) (State)

BURIAL

MAY 11 1955

ST. STANISLAUS CEMETERY

BALTIMORE (DUNDALK) MD.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

MARIE E. PLAKOWSKI & SONS 1000 S. KENWOOD AVE., BALTIMORE, MD.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-10-53



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4469

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0445538

1 PLACE OF DEATH COUNTY <u>BALTO.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>26th</u> TOWN <u>CATONSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> OR TOWN <u>BALTO.</u> STREET ADDRESS (If rural give location) <u>1424 N. EDEN ST.</u>	
3 NAME OF DECEASED (First) (Middle) (Last) <u>BERTHA</u> <u>SLADE</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>5-15-1955</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 SINGLE <u>MARRIED</u> WIDOWED <u>DIVORCED</u> (Specify)	8 DATE OF BIRTH <u>about 1886</u>
9 AGE last birthday <u>about 69</u> yrs		10 MONTHS <u>5</u> DAYS <u>15</u> HOURS <u>55</u> MIN.	
10a USUAL OCCUPATION Give kind of work done during most of working life even if retired: <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>John KAKALAY</u>		14 MOTHER'S MAIDEN NAME <u>BERTHA THIEDA</u>	
15 Was DECEASED Ever in U.S. Armed Forces? (Yes, no, or unk.) (If Yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17 MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>260X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (8) D SEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STAT NG UNDERLYING CAUSE LAST (A) <u>Cerebrovascular accident</u> DUE TO (B) <u>hypertensive cerebrovascular</u> DUE TO (C) <u>disease - diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a DATE OF OPERATION		19b MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		21b PLACE (Home, farm, factory, street, office bldg. etc.)	
21c WHERE DID (City or town) (County) (State)		21d HOW DID INJURY OCCUR?	
21e TIME (Month) (Day) (Year) (Hour) OF INJURY		21f INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>7-11-</u> , <u>1929</u> , to <u>5-15-</u> , <u>1955</u> , that I last saw the deceased alive on <u>5-15-</u> , <u>1955</u> and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.			
23 BURIAL CREMATION REMOVAL (Specify)		24 FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REGISTRAR <u>5-17-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
DATE SIGNED <u>5-15-55</u>		ADDRESS <u>MD Spring Grove State Hosp. 5-15-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery Baltimore Co., Maryland</u>		LOCATION (City, town, or county) (State)	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

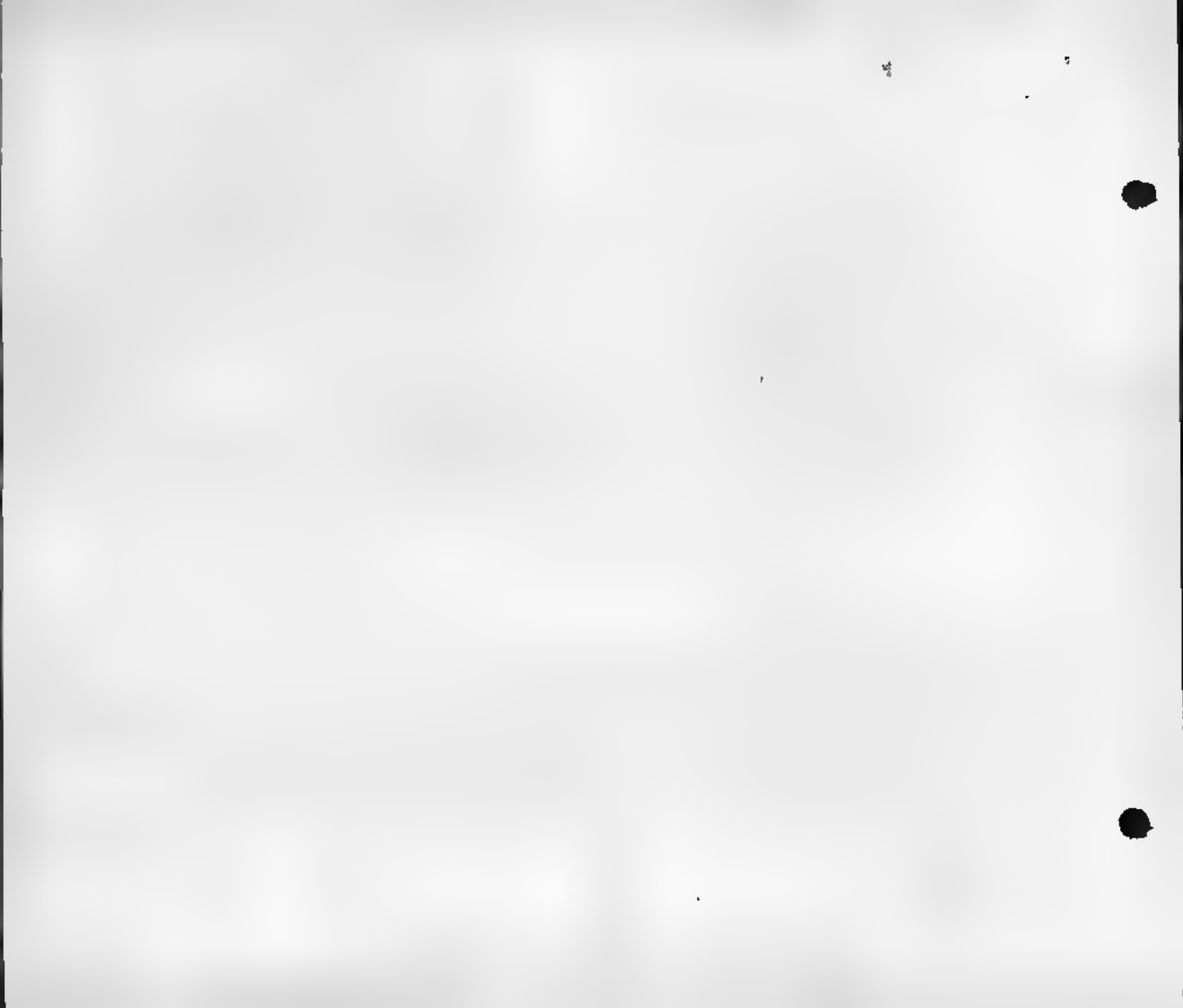
04456

4470

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY BALTIMORE MARYLAND CITY If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town 79 DAYS TOWN FORT HOWARD		STATE MARYLAND COUNTY CITY If outside corporate limits, write RURAL and give nearest town OR BALTIMORE (TOWSON) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 251 RIDGE AVENUE	
3 NAME OF DECEASED (Type or Print) (First) (Middle) (Last) EDWIN L. SLAYSMAN		4 DATE (Month) (Day) (Year) OF DEATH MAY 25 19 55	
5 SEX (Type or Print) MALE 6 COLOR OR RACE WHITE 7 SINGLE MARRIED WIDOWED DIVORCED Specify MARRIED		8 DATE OF BIRTH 1-23-99 9 AGE last birthday 56 yrs	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) TIMEKEEPER 10B KIND OF BUSINESS OR INDUSTRY BENDIX		11 BIRTHPLACE (State or foreign country) GOVANS, MARYLAND 12 CITIZEN OF WHAT COUNTRY U. S. A.	
13 FATHER'S NAME LONZO SLAYSMAN		14 MOTHER'S MAIDEN NAME ELIZABETH SOUTHCOMB	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give was or dates of service) YES		16 SOCIAL SECURITY NO 219-01-6310	
17 INFORMANT & ADDRESS CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.			
18 MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN	
155X IMMEDIATE CAUSE (A) PRIMARY CARCINOMA OF LIVER ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION:		19B MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory, office, street, etc.) OF INJURY	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E INJURY OCCURRED While at work Not while at work	
22 I hereby certify that I attended the deceased from MAR. 7, 1955, to MAY 25, 1955, and that death occurred at 8:40 A.M. from the causes and on the date stated above.		21F HOW DID INJURY OCCUR?	
SIGNATURE OF REGISTRAR WILLIAM B. VANDERKRIEF, M.D.		ADDRESS M D VAH, FORT HOWARD, MARYLAND 5-25-55	
23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county, (State) Baltimore National Cemetery Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 5-26-55		REGISTRAR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Road Baltimore 14, Md.	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

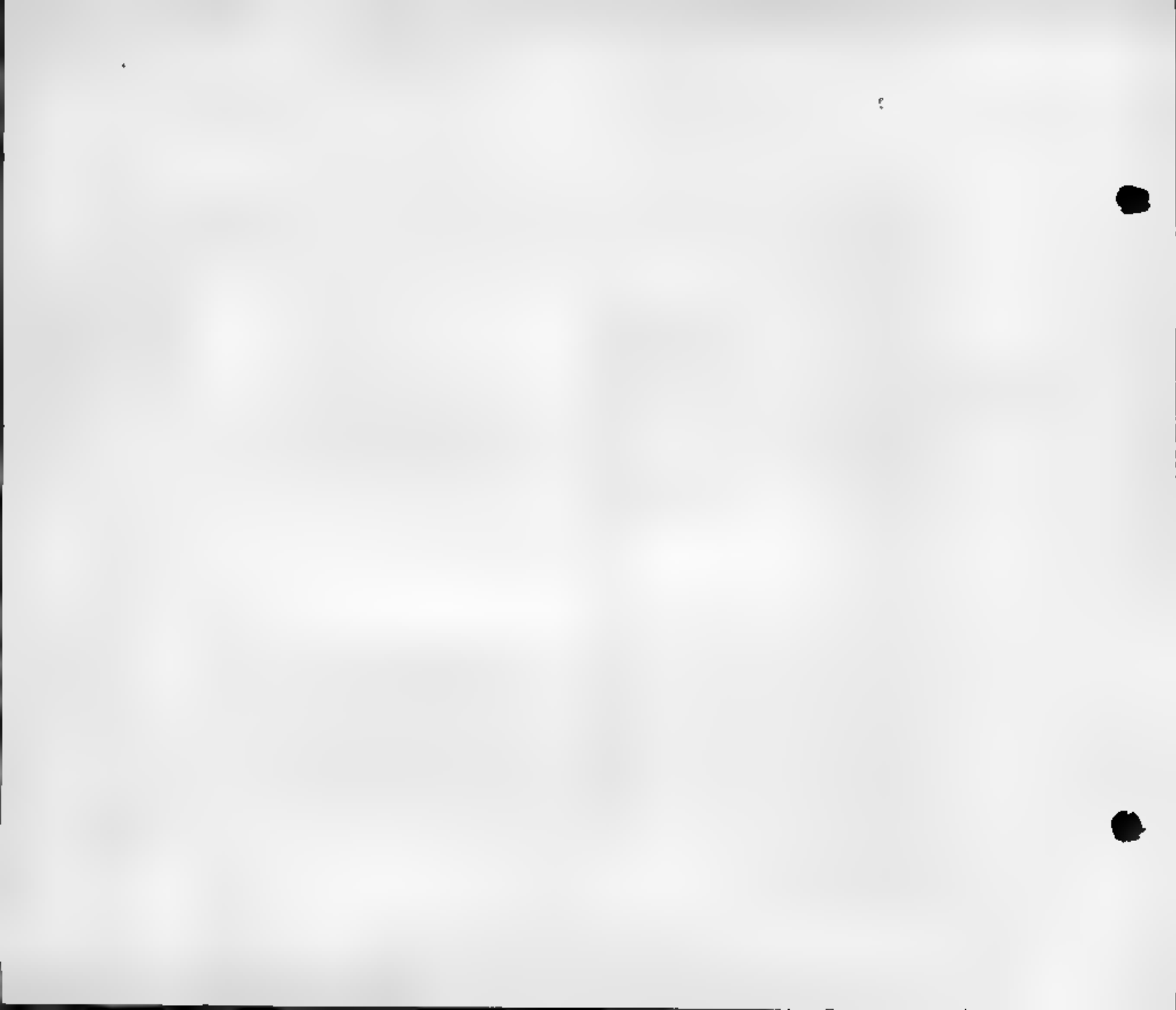
4471

CERTIFICATE OF DEATH

Reg. Dist. No.

04457

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	BALTIMORE	STATE	MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)	FORT HOWARD,	COUNTY	
OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	BALTIMORE
HOSPITAL OR INSTITUTION OR STREET ADDRESS	VETERANS ADMINISTRATION HOSPITAL	STREET ADDRESS (If rural give location)	620 SARAH ANN STREET
3 NAME OF DECEASED (First) (Middle) (Last)	ALBERT B. SMITH	4 DATE (Month) (Day) (Year)	May 28 1955
5 SEX	MALE	6 COLOR OR RACE	COLORED
7 SINGLE MARRIED	WIDOWED	8 DATE OF BIRTH	3-1-93
9 AGE last birthday	62	10 AGE last birthday	62
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	LABORER	10b KIND OF BUSINESS OR INDUSTRY	CONTRACTING
11 BIRTHPLACE (State or foreign country)	BALTIMORE, MARYLAND	12 CITIZEN OF WHAT COUNTRY?	U. S. A.
13 FATHER'S NAME	LOUIS SMITH	14 MOTHER'S MAIDEN NAME	MARY SMITH
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	YES	16 SOCIAL SECURITY NO	UNKNOWN
17 INFORMANT & ADDRESS	CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	18 MEDICAL CERTIFICATION	
19a DATE OF OPERATION	0	19b MAJOR FINDINGS OF OPERATION	
20 THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		21 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH	OBESITY, ASTHMA, CIRRHOSIS OF LIVER
22 I hereby certify that I attended the deceased from MAY 21, 1955, to MAY 28, 1955, and that death occurred at 6:05 AM from the causes and on the date stated above.		23 BURIAL (Specify)	Burial
24 DATE REC'D BY LOCAL REGISTRAR	5-31-55	25 REGISTRAR'S SIGNATURE	A. W. Hedrick
26 FUNERAL DIRECTOR	Arlington S. Phillips Funeral Home	27 ADDRESS	1808 N. Monroe Street, Baltimore 17, Md.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4472

CERTIFICATE OF DEATH

Reg. Dist. No. 04458

1 PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY <u>CATONSVILLE</u> OR TOWN HOSPITAL OR INST TUT ON OR STREET ADDRESS <u>House in the Pines 16 Justing Ave</u>		2 USUAL RESIDENCE (HOME OF DECEASED) STATE <u>MD</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> 3Y-1-4 STREET ADDRESS (If rural give location) <u>435 S. Parrish St</u>	
3 NAME OF DECEASED (Type or Print) <u>BERNICE P. Smith</u> SEX <u>FEMALE</u> COLOR OR RACE <u>WHITE</u> 6 CO OR OR 17 SINGLE MARRIED <u>MARRIED</u> 8 DATE OF BIRTH <u>FEB 6, 1907</u> 9 AGE last birthday 48 yrs Months Days Hours Min.		4 DATE OF DEATH <u>MAY 25</u> 19 <u>55</u>	
10A USAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>AW</u> 10B KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) <u>BRISFIELD MD</u> 12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME <u>P</u> 14 MOTHER'S M A D E N NAME <u>P</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) <u>No</u> (If Yes, give war or dates of service) 16 SOCIAL SECURITY NO		17 INFORMANT'S ADDRESS <u>Ralph M. Fullum 435 S. Parrish St</u>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE <u>331X</u> ANTECEDENT CAUSE (B) DISEASES OR COND TIONS IF ANY G V N G RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (A) <u>Cerebral Hemorrhage</u> DUE TO (B) <u>Hypertension</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>2 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR COND T ON CAUSING DEATH			
18A DATE OF OPERATION		18B MAJOR FINDINGS OF OPERATION	
21A ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIB JTNG CAUSE OF DEATH (If either, NOTIFY MED CAL EXAMINER)		21B PLACE Home, farm, factory, street, office bldg., etc	
21C WHERE DID (City or town) (County) (State)		21D TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-18, 1954</u> , to <u>5-25, 1955</u> , that I last saw the deceased alive on <u>5-25, 1955</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above SIGNATURE <u>William K. Gallagher</u> ADDRESS <u>MD Catonsville 628, Md.</u> DATE SIGNED <u>5-26-55</u>			
23 BURIAL CREMATION REMOVAL (SPECIFY) <u>BURIAL</u> DATE THEREOF <u>5/28/55</u> NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u> LOCATION <u>Balto Co. Md.</u>		24 REGISTRAR'S SIGNATURE <u>W. D. McLeod</u> ADDRESS <u>1011 O. B. M. Walters</u>	

DATE REC'D BY LOCAL REGISTRAR

6-22-55

REGISTRAR'S SIGNATURE

W. D. McLeod

FURNERIAL DIRECTOR

R. B. M. Walters

ADDRESS

1011 O. B. M. Walters

4473

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1 PLACE OF DEATH:

COUNTY

Balt.

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) 70 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md

COUNTY

Balt.

CITY (If outside corporate limits, write RURAL and give nearest town) Fork Md

STREET ADDRESS

If rural give location

3 NAME OF DECEASED

(First)

(Middle)

(Last)

Joseph Lester Smith

4 DATE OF DEATH

(Month)

(Day)

(Year)

May 21 1955

5 SEX:

6 COLOR OR RACE

7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8 DATE OF BIRTH

9 AGE last birthday

10 UNDER 1 YEAR 11 UNDER 24 HRS

M.

W.

Widowed

May 2-1875

80 yrs

10a. USUAL OCCUPATION Give kind of work done during most of working life even if retired: Post man Ret post master

11 BIRTHPLACE State or foreign country: Md.

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME

Joseph L. Smith

14 MOTHER'S MAIDEN NAME:

Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)

no

16 SOCIAL SECURITY NO

17 INFORMANT & ADDRESS

Joseph Smith Fork Md.

18. MEDICAL CERTIFICATION

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44:2 Immediate cause

Ac. Bronchopneumonia

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

DUE TO

Cerebral Thrombosis

DUE TO

Hypertensive Cardiovascular Dis- cardiac Decompensation

Interval Between Onset and Death

4 days

7 days

10 days

11 OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21 ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office, etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 10, 1955, to May 21, 1955, that I last saw the deceased

live on May 21, 1955 and that death occurred at 8:45 PM from the causes and on the date stated above

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BY REMOVAL, CREMATION, OR OTHER (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

May 24-55

C. E. Arthur

G. E. Arthur

Fork Md

D. L. Ladd, Reg.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly

U.S. AIR FORCE

SEP 7 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No

4474

1 PLACE OF DEATH:

COUNTY Baltimore STATE Maryland COUNTY Balto

CITY (If outside corporate limits write RURAL LENGTH OF STAY OR and give nearest town) (In this place)

TOWN Rodgers Forge

HOSPITAL OR INSTITUTION OR STREET ADDRESS 203 Murdock Rd STREET ADDRESS (If rural give location) 203 Murdock Road

3 NAME OF DECEASED (Type or Print) First (Middle) (Last) Johanna Stahl

4 DATE OF DEATH (Month) (Day) (Year) MAY 10 - 1955

5 SEX Female 6 COLOR OR RACE White 7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed 8 DATE OF BIRTH Jan. 29, 1867 9 AGE last birthday (Yr) (Mo) (Day) (Hr) (Min) 88 yrs

10a USUAL OCCUPATION Give kind of work done during most of working life, (specify if retired) Homemaker 10b KIND OF BUSINESS OR INDUSTRY Homemaker 11 BIRTHPLACE (State or foreign country) Germany 12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Herman Wessenhilder 14 MOTHER'S MAIDEN NAME Bertha Hammer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes give war or dates of service) No 16 SOCIAL SECURITY NO Louise Peusche 203-Murdock 17 INFORMANT & ADDRESS: Louise Peusche 203-Murdock

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X Immediate cause (a) UREMIA DUE TO

Antecedent causes (b) ARTERIO SCLEROTIC C.V. DISEASE - HYPERTENSION DUE TO

(c)

19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death THYROID ADENOMA

19a. DATE OF OPERATION 2 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY Yes ☐ No ☒

21 ACCIDENT (Specify) SLIDE HOMICIDE PLACE (Home, farm, factory street, OF office bldg etc. (CITY OR TOWN) (COUNTY) (STATE)

INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950 to MAY 10, 1955, that I last saw the deceased alive on MAY 9, 1955, and that death occurred at 1:10 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Edward J. Zepf M.D. ADDRESS 427 Sophie Rd. Bowie Md. 5/11/55

23. BURIAL, CREMATION, DATE THEREOF, NAME OF CEMETERY OR CREMATORY, LOCATION (City town or county) (State)

Burial May 12-55 Mounting Park Woodlawn - Md.

DATE RECD BY LOCAL REGISTRAR'S SIGNATURE 5/11-55 24. FUNERAL DIRECTOR ADDRESS Edw. J. Zepf 1300 Fawcett Pl.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important Physicians write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04461

4475

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3611 Kensington Ave</u>		STREET ADDRESS (If rural, give location) <u>3611 Kensington Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Marshall</u> (Middle) <u>Pinard</u> (Last) <u>Streett</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 10</u> 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 10</u> 189 <u>0</u>
9. AGE last birthday <u>58</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer - Baltimore</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>James P. Streett</u>		14. MOTHER'S MAIDEN NAME <u>Martha D. Streett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>24-01-9670</u>	
17. INFORMANT AND ADDRESS <u>Marshall Pinard Streett, 3611 Kensington Ave, Rockdale, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>
Immediate cause <u>(a) Anomalous Carcinomatosis</u>			
Antecedent cause(s) <u>(b) Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(c) -</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/10, 1949, to 5/10, 1955, that I last saw the deceased alive on 5/10, 1955, and that death occurred at 11:20 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

04462

Item 14, File G182, 6/9/55 fcy

Reg. Dist. No.

1 PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
CITY (If outside corporate limits write RURAL and give nearest town)
OR TOWN DUNDALK LENGTH OF STAY
in this place:HOSPITAL OR
INSTITUTION OR
STREET ADDRESS 55 NORTHSHIP

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY BALTO.
CITY (If outside corporate limits write RURAL and give nearest town)
OR TOWN DUNDALKSTREET ADDRESS (If rural give location)
55 NORTHSHIP3 NAME OF DECEASED: First Middle Last
(Type or Print) IDA BELL STUMP4 DATE OF DEATH MAY 30 19 55
5 SEX FEMALE 6 COLOR OR RACE WHITE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED 8. DATE OF BIRTH: APRIL 5, 1876 79 yrs. Mon. Days Hours Min.10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) At Home 10b. KIND OF BUSINESS OR INDUSTRY. PENNA 11 BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME.

MICHAEL KERN

14. MOTHER'S MAIDEN NAME

Amanda Cooper15. Was Deceased Ever in U.S. Armed Forces? (Yes, no, or unk) (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY No. 17. INFORMANT & ADDRESS

RALPH F. MATTOX 55 NORTHSHIP

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181X
Immediate cause (a) Carcinomatosis

Antecedent causes (b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

11 OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home farm, factory street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED
OF INJURY m. While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUN 1944, to MAY 30, 1955, that I last saw the deceased alive on MAY 30, 1955, and that death occurred at 8:20 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

6-1-55G. W. KeoluekVLLRICH FUNERAL HOMEDUNDALK

RE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of informat on carefully. The correct age is especially important. Physicians please write the causes of death early and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04463

4476

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town, OR TOWN <u>Dorchester Md</u> LENGTH OF STAY (in this place) <u>7 yrs 10 mo</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u></u> CITY (If outside corporate limits, write RURAL and give nearest town, OR TOWN <u>Baltimore Md</u> STREET ADDRESS (If rural give location) <u>729 W. 34th St</u>	
3 NAME OF DECEASED First <u>Louis</u> Middle <u>Mason</u> Last <u>Taylor</u> Type or Print		4 DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1955</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 SINGLE MARRIED WIDOWED DIVORCED (Specify) <u>None</u>	8 DATE OF BIRTH <u>Jan 19-1861</u> 9 AGE last birthday <u>94</u> yrs <u>14</u> months <u>14</u> days <u></u> hours <u></u> min.
10A USUAL OCCUPATION Give kind of work done during most of working life even if retired <u>Housewife</u>		10B KIND OF BUSINESS OR INDUSTRY <u>Frederickburg Va</u>	11 BIRTHPLACE (State or foreign country) <u>Frederickburg Va</u>
12 CITIZEN OF WHAT COUNTRY? <u>Frederickburg Va</u>		13 FATHER'S NAME <u>John T. Drington</u>	
14 MOTHER'S MAIDEN NAME <u>Sophia Hittles</u>		15 INFORMANT & ADDRESS <u>Laura H. Schroeder</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		17 SOCIAL SECURITY NO <u>None</u>	
18 MEDICAL CERTIFICATION 18A DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>Cardio Vascular Disease 1 yr?</u> ANTECEDENT CAUSE (B) <u>Arterio sclerosis</u> DUE TO DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory of INJURY street, office bldg., etc.)	
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1947</u> to <u>May 21, 1955</u> , that I last saw the deceased alive on <u>May 21</u> , 1955, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Valentin T. Lees</u> ADDRESS <u>Cockeyville</u> DATE SIGNED <u>23 May 1955</u> M D			
23 BURIAL CREMATION, DATE THEREOF, NAME OF CEMETERY OR CREMATORY, LOCATION (City, town or county) (State)			
24 REG. BY LOCAL REGISTRAR <u>May 24, 1955</u>		25 REGISTRAR'S SIGNATURE <u>L. H. Schroeder</u>	
26 FUNERAL DIRECTOR <u>Paul Chenoweth</u>		27 ADDRESS <u>360 Chestnut Ave</u>	

TWO FOR ONE CERTIFICATE - FILM G182 - 5/27/55 - mb

(copies given from other certificate)

RECEIVED

WVA

1955

4477

MARYLAND STATE DEPARTMENT OF HEALTH

04464

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

37

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		5. AGE last birthday	
(First) (Middle) (Last)		(Month) (Day) (Year)		If under 1 year If under 24 hrs.	
6. SEX		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
9. COLOR OR RACE		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired		11. BIRTHPLACE (State or foreign country)	
12. FATHER'S NAME		13. MOTHER'S MAIDEN NAME		14. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT	
(If yes, give war or dates of service)					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Sudden	
420.1 Immediate cause (a) Coronary Thrombosis			
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		20. AUTOPSY?	
19b. MAJOR FINDINGS OF OPERATION		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.)	
CAUSE OF DEATH		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by and Autopsy Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE		DATE SIGNED	
(Degree or title)			
23. BURIAL, CREMATION, REMOVAL (Specify)		24. FUNERAL DIRECTOR	
DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		ADDRESS	
9 May 1955		d'Avre de Grac	

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

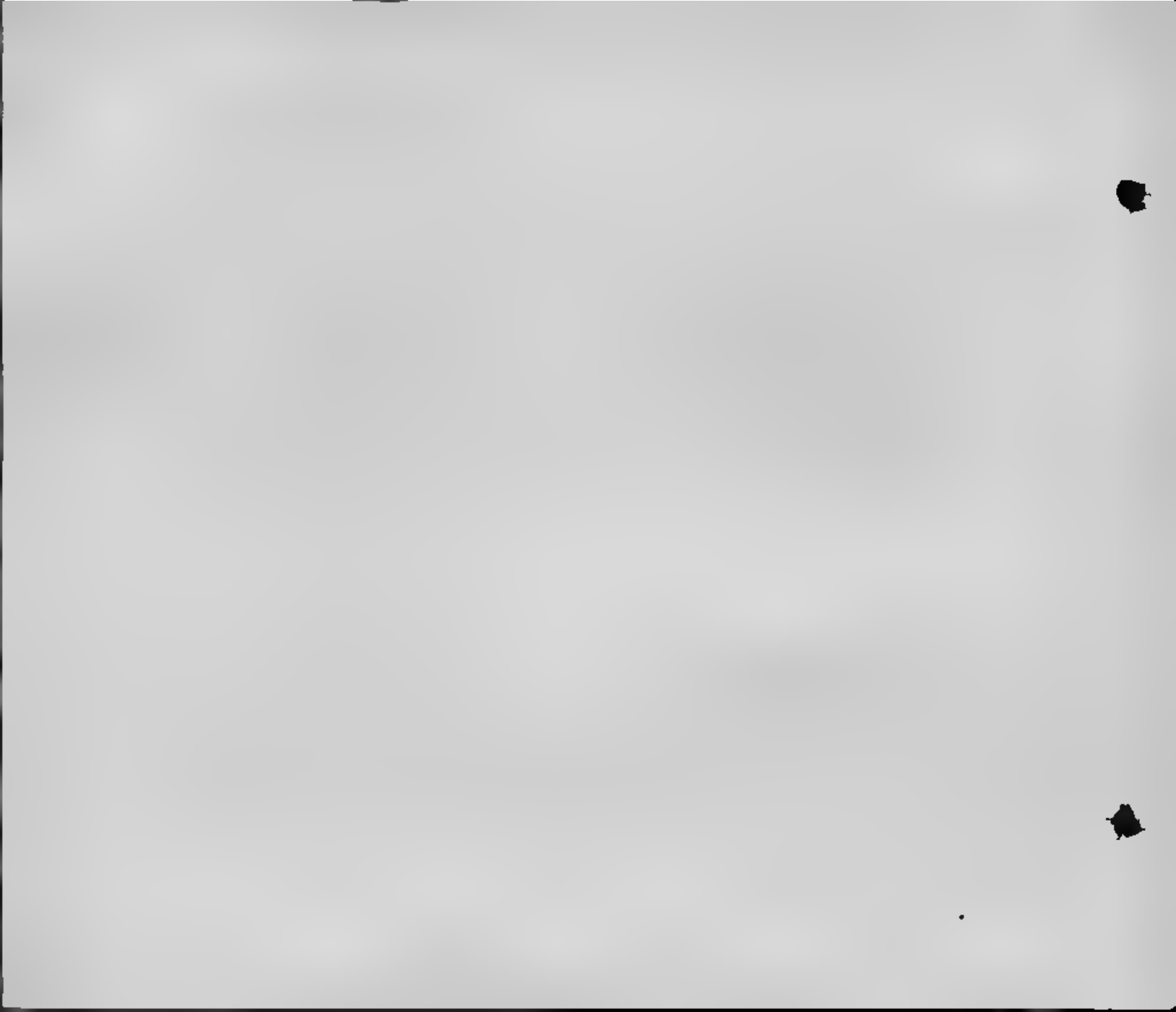
3 1 1 1 1

1 1 1 1 1

1 1 1 1 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4470 MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18				04465 Reg Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.					
1 PLACE OF DEATH:			2 USUAL RESIDENCE (HOME) OF DECEASED.		
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY 1.	
CITY (If outside corporate limits, write RURAL OR and give nearest town.)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN TOWSON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		9400 HARFORD ROAD		STREET ADDRESS (If rural, give location) 520 HAMPTON LANE	
3. NAME OF DECEASED (First) (Middle) (Last)		ROLAND E THURSBY JR.		4. DATE OF DEATH (Month) (Day) (Year) May 30 1955	
5. SEX: Male		6. COLOR OR RACE: white		7. SINGLE OR MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY: SCHOOL		8. DATE OF BIRTH: OCTOBER 8, 1947	
12. CITIZEN OF WHAT COUNTRY? USA		11. BIRTHPLACE (State or foreign country, BALTIMORE MD.)		9. AGE last birthday. ? yrs. Months Days Hours Min.	
13. FATHER'S NAME: ROLAND E. THURSBY		14. MOTHER'S MAIDEN NAME: A. GLORIA STINCHECUM			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or UNK.) NO		16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS: MR. & MRS. ROLAND E. THURSBY SAME.	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
9-6-4 Immediate cause (a) Asphyxia secondary to aspiration of vomitus DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE Home, farm, factory, OF street, office, bldg., etc. INJURY		21c. (City or town) (County, State) Baltimore Md.	
21d. TIME (Month) (Day) (Year) Hour) OF INJURY 5/30/55 5:20pm		21e. INJURY OCCURRED While at work <input type="checkbox"/> On <input checked="" type="checkbox"/> Not while work		21f. HOW DID INJURY OCCUR? Struck in chest by baseball.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE Paul R. Green		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF NAME OF CEMETERY OR REPOSITORY LOCATION (City, town or county) (State)			
BURIAL		JUNE 3, 1955 DRUID RIDGE CEMETERY PIKESVILLE MD.			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND. George Sander	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04465

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rodgers Forge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rodgers Forge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>320 Murdock Road</u>				STREET ADDRESS <u>320 Murdock Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First, <u>Bessie</u>)		(Middle, <u>Bell</u>)		(Last, <u>Waesche</u>)		(Month, <u>May</u>)	
(Type or Print, <u>Female</u>)						(Day, <u>28</u>)	
5. SEX:		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Sept. 26, 1879</u>	
						9. AGE last birthday: <u>75</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
13. FATHER'S NAME: <u>John C. Bell</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS <u>J. Edward Waesche 320 Murdock Road</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Primary Esclusin</u> DUE TO							
Antecedent cause(s) (b) <u>Arterio sclerosis</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) STATE	
TIME (Month) (Day) Year (Hour)		INJURY OCCURRED While at work Not while at work		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>46</u> to <u>28 May 1955</u> , that I last saw the deceased alive on <u>28 May 1955</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(DEGREE OR TITLE, ADDRESS <u>MD 6201 York Rd Baltimore Md</u>)		DATE SIGNED <u>28 May 1955</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>		LOCATION City, town, or county: <u>Garrison Forest, Md.</u>	
DATE RECD BY LOCAL REG. <u>5-31-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedgcock</u>		24. FUNERAL DIRECTOR <u>John O. Mitchell</u>		ADDRESS	

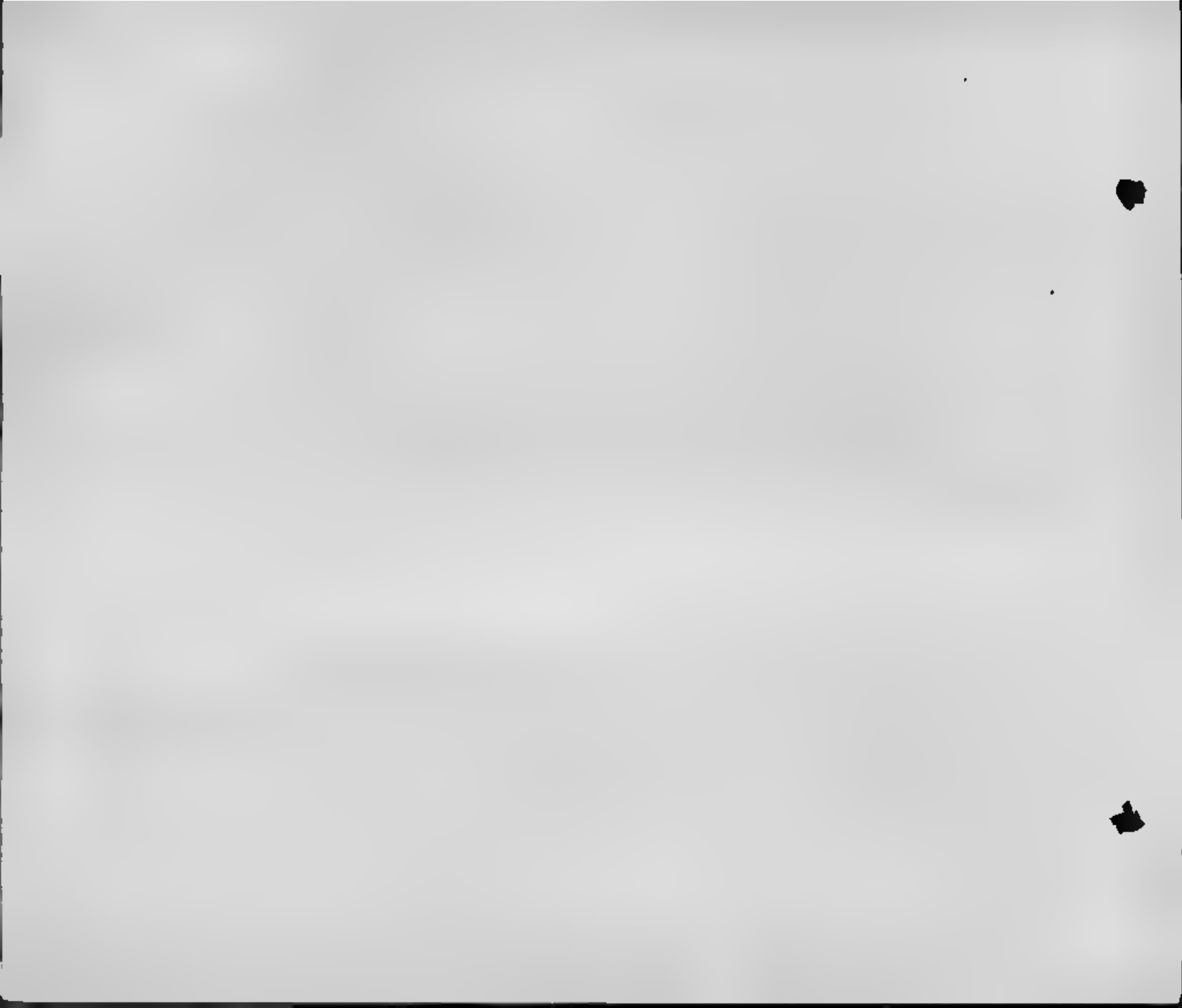


PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death, clearly and legibly.

4480 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

014467
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bellevue</u>	LENGTH OF STAY (In this place) <u>4 1/2 days</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3601 4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Agnes Hospital</u>		STREET ADDRESS (If rural, give location) <u>1207 ...</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Louise</u>	(Middle) <u>Marie</u>	(Last) <u>Walker</u>	(Month) <u>May</u> (Day) <u>24</u> (Year) <u>1955</u>
5. SEX. <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>	8. DATE OF BIRTH: <u>9-27-1901</u>
9. AGE last birthday <u>53</u> yrs		10. BIRTHPLACE (State or foreign country) <u>Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Secretarial</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles A. Walker</u>		14. MOTHER'S MAIDEN NAME: <u>Marie L. ...</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Unknown</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
<p>9177 Immediate cause (a) DUE TO <u>Septicemia</u></p> <p>Antecedent cause(s) (b) DUE TO <u>Body scalded over 3/4 of body</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Lower part 2nd degree burn</u></p>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetic Mellitus</u>			
19a. DATE OF OPERATION.		19b. MAJOR FINDING OF OPERATION.	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg, etc., INJURY <u>Hospital</u>)	21c. (City or town) <u>Cabinville</u> (County) <u>Baltimore</u> (State) <u>Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 16 55 12 M</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Scalded herself in bath tub heated w/h</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
SIGNATURE <u>W. S. McKieffer</u>		1010 leads in CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>May 24, 95</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> LOCATION <u>1/2 Baltimore</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>20-55</u>		24. FUNERAL DIRECTOR <u>Mr. Cook</u> ADDRESS <u>1217 St Paul St</u>	



4340

CERTIFICATE OF DEATH

Reg. Dist No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1 PLACE OF DEATH.

COUNTY BALTO MARYLAND
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) 1 YR.
TOWN DUNDALK
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2617 YORKWAY

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE MD COUNTY BALTO.
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK (22)
TOWN DUNDALK (22)
STREET ADDRESS (If rural, give location) 2617 YORKWAY

3 NAME OF DECEASED (Type or Print)

First

(Middle)

(Last)

5 SEX.

6 COLOR OR RACE

7 SINGLE, MARRIED, WIDOWED, DIVORCED.

8 DATE OF BIRTH.

9 DATE OF DEATH:

(Month)

(Day)

(Year)

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country)

12 (CITIZEN OF WHAT COUNTRY?)

13 FATHER'S NAME:

14 MOTHER'S MAIDEN NAME

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.); (If Yes, give war or dates of service)

16 SOCIAL SECURITY No.

17 INFORMANT & ADDRESS.

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

DUE TO

DUE TO

(c)

11 OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21 ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE Home farm, factory, street, OF office bldg, etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month, (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED White at Work Not White At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1953 to May 20 1955, that I last saw the deceased alive on May 20, 1955, and that death occurred at 6:15 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23 SPECIAL CREMATION, (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

RECEIVED
MAY 2 1964
BUREAU V. S.

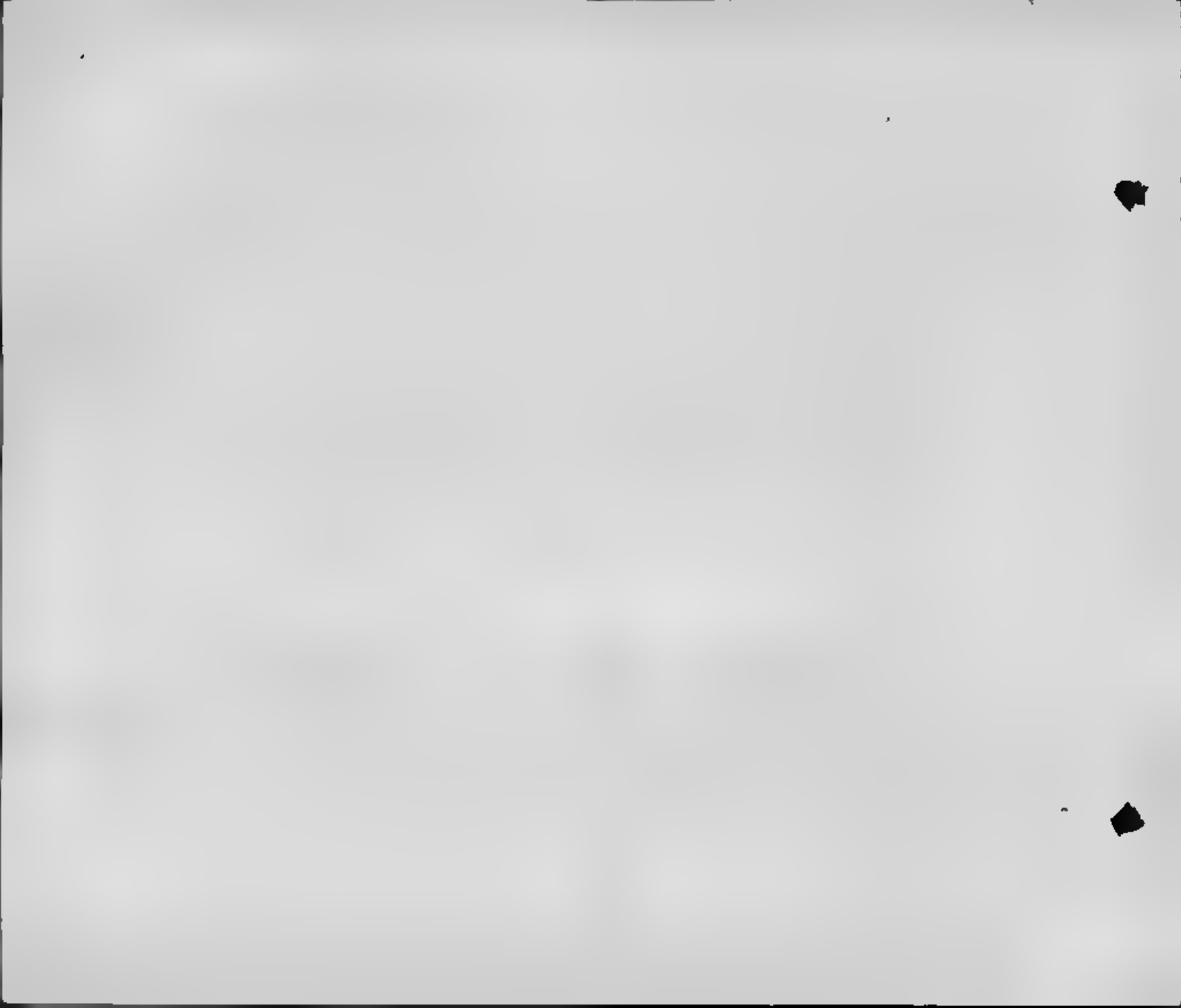
PLEASE WRITE PLAINLY, WITH UNFADING INK Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4491

4-481 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

04469

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>CATONSVILLE</u>	<u>1 year, 11 mo</u>	OR TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>SPRING GROVE ST. Hvy</u>		<u>8014 Eastern Av</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <u>Mary Ellen Wheatley</u>		(Month) (Day) (Year) <u>5 29 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-15-1879</u>
9. AGE last birthday <u>75</u> yrs		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country)	
		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		<u>U S B</u>	
13. FATHER'S NAME:		14. MOTHER'S MARDEN NAME.	
<u>James Wheatley</u>		<u>Mary Ellen Schaeffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT'S ADDRESS:			
<u>Hospital records</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
7-27 Immediate cause (a) DUE TO <u>Auto cardiac failure</u>			
Antecedent cause(s) (b) DUE TO <u>Pneumonia</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Fracture of hip</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Head and</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Home</u>	
21c. (City or town) (County) (State) <u>Catonsville Baltimore - Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 12 1955 7 AM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Fall on left side on floor</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> ; Accident <input checked="" type="checkbox"/> ; Suicide <input type="checkbox"/> ; Homicide <input type="checkbox"/> ; Undetermined cause <input type="checkbox"/>			
SIGNATURE <u>Jeffrey Kieffer</u>		1010 Reeds Ln	
CHIEF MEDICAL EXAMINER		DATE SIGNED <u>May 30 1955</u>	
DEPUTY MEDICAL EXAMINER			
M. D. ASSISTANT MEDICAL EXAM			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>June 2 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		LOCATION (City, town or county) (State) <u>BALTIMORE CO MD</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>G. L. V. St. John</u>		24. FUNERAL DIRECTOR <u>Wm Cooks-Blythe, Inc</u>	
REG <u>6-1-55</u>		ADDRESS <u>6009 Harford Rd</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4482

CERTIFICATE OF DEATH

Reg. Dist. No. 044241

1 PLACE OF DEATH				2 USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND CITY <u>CATONSVILLE</u> OR TOWN <u>CATONSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE</u>				STATE <u>MD.</u> COUNTY <u>BALTIMORE</u> CITY (if outside corporate limits write RURAL and give nearest town) OR TOWN <u>OWINGS MILLS</u> STREET ADDRESS (If rural, give location) <u>PLEASANT HILLS</u>			
3 NAME OF DECEASED Type or Print First Middle Last <u>EDWIN</u> <u>WARREN</u> <u>WHITE</u>				4 DATE OF DEATH Month Day Year <u>MAY</u> <u>7</u> <u>1955</u>			
5 SEX <u>M</u> 6 COLOR OR 7 SINGLE MARRIED W DOWED DIVORCED (Specify) <u>SINGLE</u>				8 DATE OF BIRTH <u>1/11/07</u>			
9 AGE <u>48</u> yrs				10 BIRTHPLACE State or foreign country <u>MD.</u>			
11 BIRTHPLACE State or foreign country <u>MD.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>EDWIN G. WHITE</u>				14 MOTHER'S MAIDEN NAME <u>CHATTYE ROLLINS</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>				16 SOCIAL SECURITY NO. <u>?</u>			
17 INFORMANT'S ADDRESS <u>HOSPITAL RECORDS</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>752X TERMINAL PNEUMONIA</u>							
ANTECEDENT CAUSE (B) <u>HYDROCEPHALUS EPILEPSY</u>							
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>HYDROCEPHALUS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>SCHIZOPHRENIA - 20YRS.</u>							
19A DATE OF OPERATION				19B MAJOR FINDINGS OF OPERATION			
21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER				21B PLACE (Home farm factory or INJURY street office bldg)			
				21C WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D TIME (Month Day Year) (Hour) OF INJURY				21E INJURY OCCURRED While at work Not while at work			
				21F HOW DID INJURY OCCUR?			
22 I hereby certify that I attended the deceased from <u>NOV. 30, 1937</u> to <u>MAY 7, 1955</u> , that I last saw the deceased alive on <u>MAY 7, 1955</u> , and that death occurred at <u>745P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles Ward M.D.</u> ADDRESS <u>M.D. Spring Grove Hosp.</u> DATE SIGNED <u>5/7/55</u>							
23 BURIAL CREMATION REMOVAL SPECIFY DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City or town or county) (State)							
<u>Burial</u> <u>May 9/55</u> <u>Druid Ridge</u> <u>Pineville</u>							
DATE PEC'D BY LOCAL REGISTRAR <u>3/8/55</u>				REGISTRAR'S SIGNATURE <u>V.E. Harris</u>			
				24 FUNERAL DIRECTOR ADDRESS <u>F. Elmer Smedley Rustonstown Md.</u>			

3 A

CERTIFICATE OF DEATH

Reg. Dist. No.

1 NAME OF DECEASED (Type or Print) <i>Henry R. White</i>			2 DATE OF DEATH <i>5-1-55</i>		
3 PLACE OF DEATH A <i>Baltimore County</i> B <i>Catonsville</i>			4 USUAL RESIDENCE (Where deceased lived, 1 month prior to date of death) A STATE <i>Md.</i> B CITY OR TOWN <i>Baltimore</i> C STREET ADDRESS (If rural give location) <i>3841 Elmley Ave.</i>		
5 FULL NAME OF DECEASED If not in hospital or institution, give street address or location <i>Harlem Lane</i> <i>Caton Ridge Nursing Home</i>			6 DATE OF BIRTH A Year <i>Nov. 6, 1881</i> B Month <i>73</i> C Day <i>73</i>		
7 SEX <i>male</i>			8 COLOR OR RACE <i>white</i>		
9 SINGLE MARRIED <i>Married</i>			10 DATE OF DEATH A Year <i>Nov. 6, 1881</i> B Month <i>73</i> C Day <i>73</i>		
11 USUAL OCCUPATION (Give kind of work during most of working life even if retired) <i>Rtd - Self Employed</i>			12 KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		
13 FATHER'S NAME <i>Henry E. White</i>			14 MOTHER'S MAIDEN NAME <i>Georgeanna Reveille</i>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>			16 SOCIAL SECURITY NO. <i>214-01-3574</i>		
17 INFORMANT <i>Mrs. B. W. Percy-3409 white Ave.</i>			18 ADDRESS		
19 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinomatosis</i> DUE TO <i>Carcinoma of Throat</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST <i>?</i> <i>?</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i>		
20 IF OPERATION WAS RELATED TO CAUSE OF DEATH ENTER IN PART I OR PART II			21 DATE OF OPERATION		
22 TIME (Month) (Day) (Year) (Hour)			23 INJURY OCCURRED		
24 HOW DID INJURY OCCUR?			25 AUTOPSY?		
26 I certify that (I) (this hospital) attended the deceased from <i>April 28</i> 19 <i>55</i> to <i>May 1</i> 19 <i>55</i> , that (I) (we) last saw the deceased alive on <i>May 1</i> 19 <i>55</i> , and that death occurred at <i>9:05 p.m.</i> from the causes and on the date stated above.			27 SIGNATURE		
28 ADDRESS			29 DATE SIGNED		
30 ATTENDING PHYSICIAN			31 MED. DIRECTOR		
32 NAME OF CEMETERY OR CREMATORY			33 LOCATION (City, town, or county)		
34 DATE RECEIVED BY LOCAL REGISTRAR			35 REGISTRAR'S SIGNATURE		
36 FUNERAL DIRECTOR			37 ADDRESS		

MIL CERTIFICATION

24A BURIAL CREMA
TION REMOVAL Specify
*Burial*24B DATE
*5/4/55*24C NAME OF CEMETERY OR CREMATORY
*Moreland Mem. Pk.*24D LOCATION (City, town, or county)
*Balto. Co. Md.*DATE RECEIVED BY
LOCAL REGISTRAR
*5-2-55*REGISTRAR'S SIGNATURE
*A W. H. H. H.*25 FUNERAL DIRECTOR
H. V. M. & Sons

ADDRESS

PLEASE TYPE OR WITH PERMANENT RECORD THIS IS A PERMANENT RECORD. DO NOT USE A BALL POINT PEN. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DEATH.



4341

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1 PLACE OF DEATH

COUNTY BALTIMORE MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN DUNDALK (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 7267 HOLABIRD AVE

2 USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY BALTIMORE
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN DUNDALK
 STREET ADDRESS 7267 HOLABIRD AVE (If rural give location)

3 NAME OF DECEASED (Type or Print) First LEWIS (Middle) EDWARD (Last) WHITE

4 DATE OF DEATH (Month) MAY (Day) 29 (Year) 1955

5 SEX MALE COLOR OR RACE WHITE

7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8 DATE OF BIRTH Aug. 14 1870

9 AGE last birthday 84 yrs. Months 1 Days 24 Hours 1 Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY Own Farm

11 BIRTHPLACE (State or foreign country) Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HAROLD WHITE

14 MOTHER'S MAIDEN NAME LUCINDA HAILEIGH

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS Ma. M. MULLIN DUNDALK MD.

18. MEDICAL CERTIFICATION

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a) DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) DUE TO

(c)

Coronary thrombosis
Arteriosclerosis C.V. Disease
Generalized Arteriosclerosis

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ☐ Yes ☐ No

21 ACCIDENT Specify: PLACE OF INJURY Home farm, factory street, office bldg., etc.,

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1955, to May 19 1955, that I last saw the deceased alive on May 15, 1955, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 1-1955 William M. Kelly John L. McManis Baltimore, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

STATE DEPARTMENT OF HEALTH

4484

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>411 Main Street</u>		STREET ADDRESS (If rural, give location) <u>411 Main Street</u>	
3. NAME OF DECEASED (Type or Print) <u>GOLDIE</u> (First) <u>ETHEL</u> (Middle) <u>WINTERS</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>November 4, 1887</u>
9. AGE last birthday <u>67</u> yrs.		10. AGE under 1 year (Months) <u>18</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Buckingham Cole</u>		14. MOTHER'S MAIDEN NAME <u>Susan Rebecca Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>216-28-7485</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Clyde Dorrell, Reisterstown, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset and Death	
Immediate cause (a) <u>Cardiac Failure</u>		<u>2 hours</u>	
Antecedent cause(s) (b) <u>Carcinoma of Descending Colon</u>		<u>4 months</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work Not While At work	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July, 1954, to May 18, 1955</u> , that I last saw the deceased alive on <u>May 18, 1955</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Charles S. McWilliams, M.D.</u>		DATE SIGNED <u>May 18, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>May 21-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Winters Cemetery</u>		LOCATION (City, town, or country) <u>New Windsor, Md.</u>	
DATE RECD BY LOCAL REG. <u>5-20-55</u>		24. FUNERAL DIRECTOR <u>Wm. Berryman & Sons - Reisterstown, Md.</u>	

MARGIN RESERVED FOR BINDING

4485

CERTIFICATE OF DEATH

Reg Dist No

44

1 PLACE OF DEATH		2 USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>FOOT HOWARD</u> LENGTH OF STAY <u>12 DAYS</u> TOWN <u>FOOT HOWARD</u>		STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) _____ OR TOWN <u>BALTIMORE</u>	
HOSPITAL OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u> INST TUTION OR STREET ADDRESS _____		STREET ADDRESS (If rural give location) <u>5 SOUTH DECKER AVENUE</u>	
3 NAME OF DECEASED (Type or Print) <u>WALTER J. WOJTKOWSKI</u>		4 DATE (Month) (Day) (Year) OF DEATH <u>MAY 16 1955</u>	
5 SEX <u>MALE</u> 6 COLOR OR RACE <u>WHITE</u> 7 SINGLE MARRIED <u>MARRIED</u> 8 DATE OF BIRTH <u>March 1, 1921</u>		9 AGE (last birthday) <u>34</u> yrs. 10 INDEX YEAR <u>1955</u> 11 UNDER 14 MRS. Months Days Hours Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Maintenance - Foreman Packing Company</u>		10B KIND OF BUSINESS OR INDUSTRY _____	
13 FATHER'S NAME <u>WALTER WOJTKOWSKI</u>		14 BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give year or dates of service) <u>YES 2</u> <u>WW II</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17 INFORMANT & ADDRESS <u>CLIN. REC. VET. ADM. HOSPITAL, FT. HOWARD, MD.</u>		18 MEDICAL CERTIFICATION	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) CHRONIC GLOMERULONEPHRITIS		UNKNOWN	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(C) DUE TO			
19 SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A DATE OF OPERATION		19B MAJOR FINDINGS OF OPERATION	
20 AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory of INJURY street, office bldg., etc)	
21C WHERE DID INJURY OCCUR? City or town _____ County _____ (State) _____			
21D TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F HOW DID INJURY OCCUR? _____			
22 I hereby certify that I attended the deceased from <u>MAY 4, 1955</u> to <u>MAY 16, 1955</u> and that death occurred at <u>12:15 M.</u> from the causes and on the date stated above			
SIGNATURE <u>Francis G. Dickey, M.D., Chief, Medical Service</u>		ADDRESS <u>VAH, Fort Howard, Maryland</u>	
DATE <u>May 20, 1955</u>		DATE SIGNED <u>5-16-55</u>	
23 BURIAL CREMATION OR REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-17-55</u>		LOCATION (City, town or county) <u>Baltimore 22, Maryland</u>	
REGISTRAR'S SIGNATURE <u>A. W. Hedgcock</u>		24 FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Blight, Inc. 6009 Harford Road Baltimore 14, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

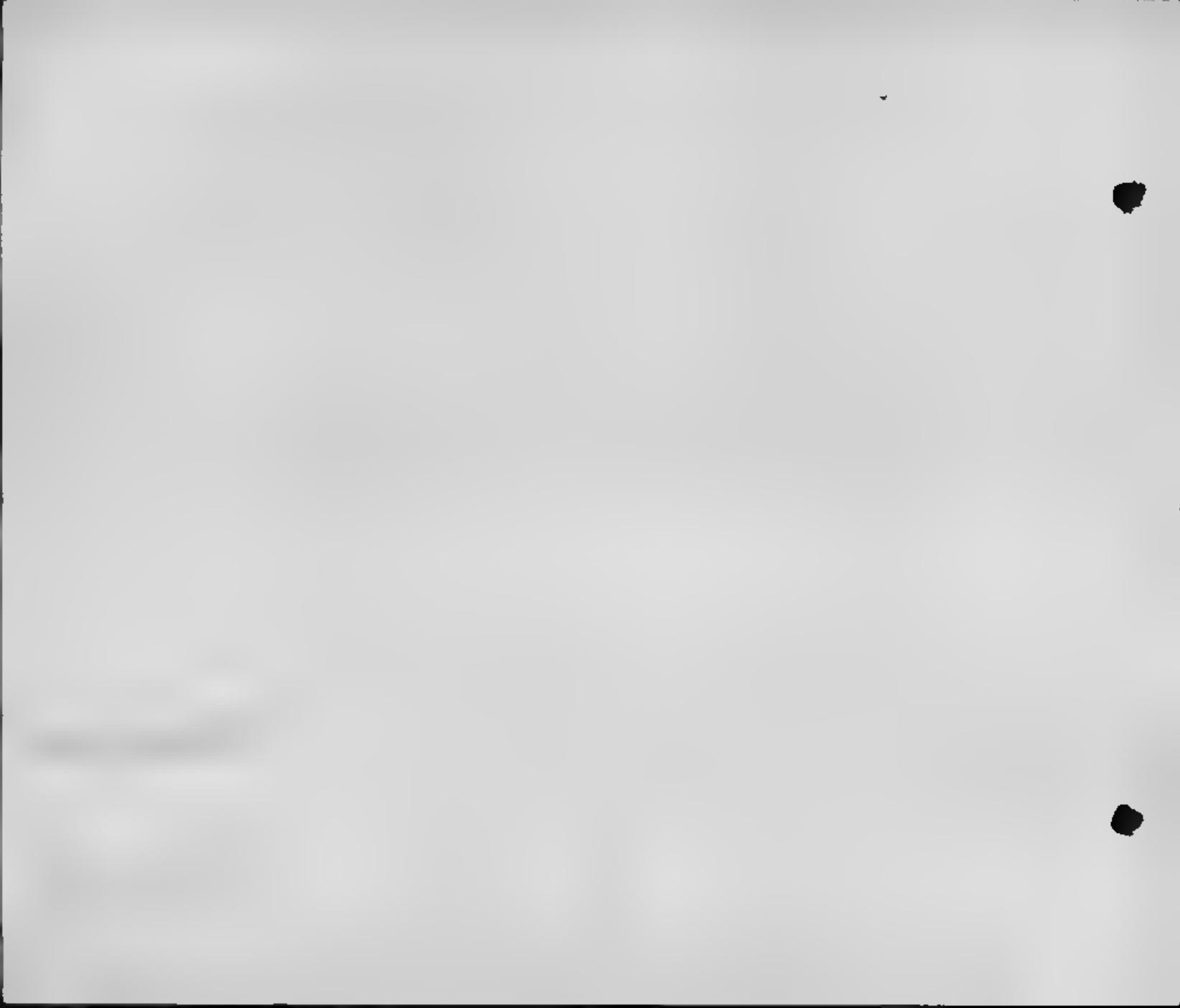


PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4486 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 3

04475
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL OR and give nearest town)				CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Randallstown		Passing through		TOWN (Gist) Sykesville, Md.		A-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
Route 26 North Branch				Rice Mill Rd. - R.F.D. 2			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Charles		(Middle) Dorner		(Last) Woodward		May 3, 1955	
5. SEX: M		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 3/13/05	
9. AGE last birthday 50 yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) auto ic		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William D. Woodward				14. MOTHER'S MAIDEN NAME: Ella Crieese			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No. 716-03-3296		17. INFORMANT & ADDRESS: Mrs. Julia Ann Woodward	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.				30 min.			
Immediate cause (a) DUE TO Coronary Artery Disease				2 yrs.			
Antecedent cause(s) (b) DUE TO Hypertensive C.V. Disease							
Diseases or conditions, if any giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				None			
19a. DATE OF OPERATION: None				19b. MAJOR FINDING OF OPERATION: None			
20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg. etc.) OF INJURY None		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY None M		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? None			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE D. D. Goplen				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/4/55			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial				DATE THEREOF 5/6/55			
NAME OF CEMETERY OR CREMATORIUM Bethesda				LOCATION (City, town or county) Gist, Md.			
DATE RECD BY LOCAL REG. 5/2/55				24. FUNERAL DIRECTOR			
REGISTRAR'S SIGNATURE Wm. E. Martin				ADDRESS 514 N. 1st St. Sykesville, Md.			



4487

CERTIFICATE OF DEATH

Reg. Dist. No. 04476

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Granite</u>	LENGTH OF STAY (in this place) <u>65 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Granite</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Philip Rudrick Zepp, Sr.</u>		OF DEATH: <u>May 8</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>Sept 28, 1888</u>
9. AGE last birthday: <u>66</u> yrs.		10. AGE last birthday: <u>66</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Shoemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Shoey Store</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George A. Zepp</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Albright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.: <u>unk</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Mabel M. Zepp, Granite, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Chr. Valvular Heart Disease</u>			
ANTECEDENT CAUSE (B) <u>Decompensation</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		1 day	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1951</u> , to <u>5/7/55</u> , that I last saw the deceased alive on <u>5/7/55</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Wm. E. Martus</u>		ADDRESS <u>Roadalltown</u> DATE SIGNED <u>5/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-11-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Balt. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/9/55</u>		24. FUNERAL DIRECTOR <u>Wm. E. Martus</u> ADDRESS <u>414 Hight - Sykesville, Md.</u>	

MARGIN RESERVED FOR BINING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 11 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04477

4348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2909 Vermont Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>3701-4</u> STREET ADDRESS (If rural give location) <u>1329 Glyndon Ave. Balto., Md</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Frank C. Zydels (Zidler--Zidels)</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 31, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>October 22, 1886-68</u> yrs.
9. AGE last birthday If under 1 year Months Days Hours Min. <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Worker</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *****		16. SOCIAL SECURITY No. <u>213-07-3939</u>	
17. INFORMANT <u>Matilda Zydels 2909 Vermont Ave.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>163X Immediate cause (a) Pulmonary Hemorrhage</u> <u>Antecedent cause(s) (b) Ca of lungs</u> <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 da</u> <u>6 wks.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>5/31</u>		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE) TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/1/55</u> to <u>5/31/55</u> , that I last saw the deceased alive on <u>5/31</u> , 19 <u>55</u> , and that death occurred at <u>8 a.m.</u> , from the causes and on the date stated above. SIGNATURE <u>Joseph G. Frankforty M.D.</u> ADDRESS <u>679 W. Channing Blvd -</u> DATE SIGNED <u>6/3/55</u>			
23. BURIAL, CREMATION, RESURRACTION, etc. (Specify) <u>Burial</u>		DATE THEREOF <u>June 4, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Belair Road Balto., Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-3-55</u>		REGISTRAR'S SIGNATURE <u>Chas. W. Kachauskas</u>	
24. FUNERAL DIRECTOR <u>Chas. W. Kachauskas</u>		ADDRESS <u>703 McHenry St. Balto., 30 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

